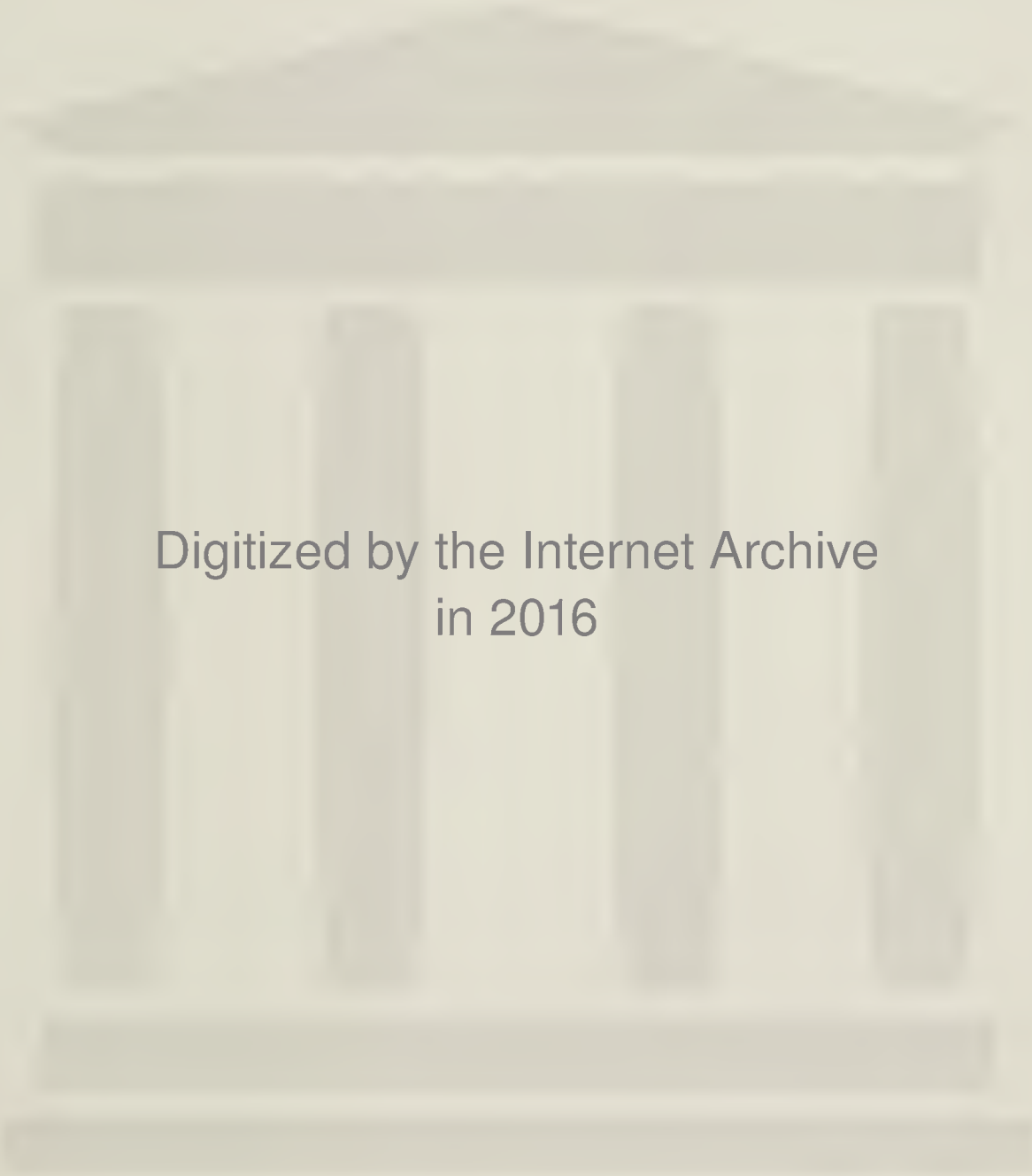




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PENNS
MEDICINE

JULY, 1970



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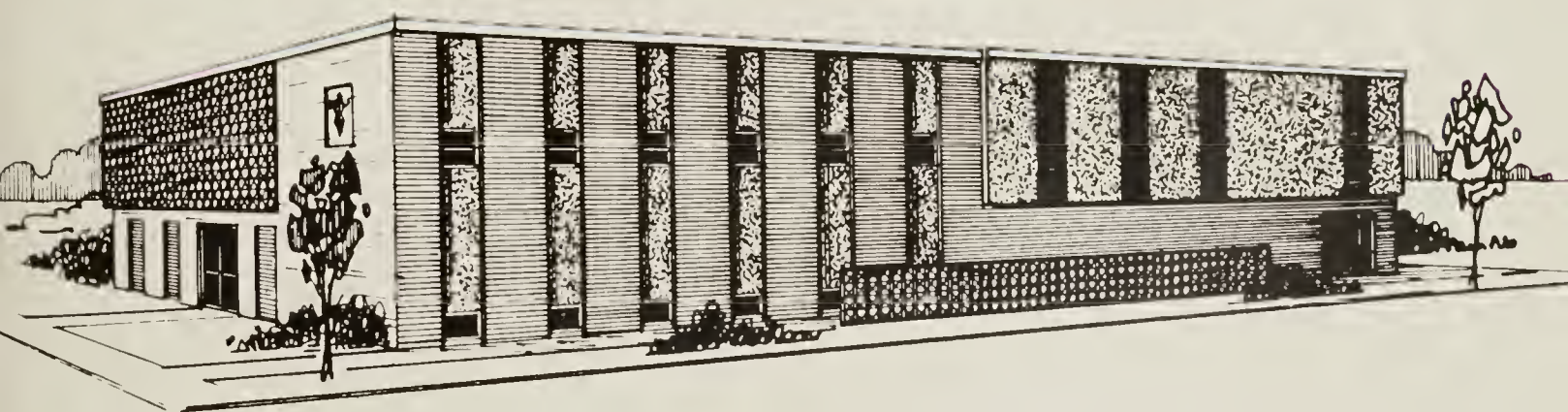
Group Practice in a Gettysburg
Civil War Field Hospital.

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Is Group Practice a Solution to the
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Treatment of Ragweed Hay Fever

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PENNSYLVANIA
MEDICINE

/medigram

JULY, 1970

COUNCIL ON MEDICAL SERVICE SPONSORS PROGRAM

Announcement of the
new major medical

benefits due to be added to the Blue Cross-Blue Shield Steel Program in August, 1970, was the highlight of a meeting sponsored by the PMS Council on Medical Service in the new home of the Allegheny County Medical Society recently. Representatives of Blue Cross, Blue Shield, the United Steelworkers of America, the steel industry and the medical profession participated in the program designed to develop a better understanding of the program and the efforts being made to assure the most efficient and effective use of the prepaid health care dollars which are available as a result of the insurance agreement existing between management and the union in the basic steel industry.

Matthew Marshall, Jr., M.D., Pittsburgh, chairman of the Council on Medical Service, represented PMS.

BOARD APPROVES USE OF VIDEO TAPED EDUCATIONAL PROGRAMS

The PMS
Board of

Trustees has approved a recommendation to encourage county medical societies to utilize video tapes on medical and socioeconomic subjects through hospital video recorders and on available time at local public television stations as part of efforts in continuing education. The Council on Education and Science made the recommendation for such action. For the cost of postage alone, such programs will be available in the near future from the Pennsylvania Department of Education. A grant of \$1,000 from the State Society will be used to start a video tape library. The three regional medical programs active in the Commonwealth are being encouraged to participate.

STATE HAS RUBELLA VACCINE

The Pennsylvania Department of Health
now has sufficient Rubella vaccine to

immunize all unimmunized children between the ages of five and twelve in the sixty-five counties exclusive of Philadelphia and Allegheny. To date both Sunday and school programs have been conducted, according to department spokesmen. In the counties where school programs were held, between 75 and 80 per cent of the children were immunized. In Sunday programs, however, the percentage of children immunized has ranged from a low of 25 per cent to a high of 57 per cent in Allegheny County. The department is recommending that the vaccine available be used in county-wide school programs. Single dose vaccine will be sent upon request to any school physician for use in individual elementary schools or school districts. Multiple-dose vaccine, jet injector guns and assistance can be supplied. For information contact W. D. Schrack, Jr., M.D., Director, Division of Communicable Diseases, P.O. Box 90, Harrisburg, Pa. 17120.

PMS REPRESENTED AT GROUP PRACTICE MEET

O. K. Stephenson, M.D.,
chairman of the Committee on

General Practice, recently represented the Society at the First International Congress on Group Practice held in Winnipeg, Canada. Socio-economic changes affecting health care, community health unit plans, and medicine's responsibility to society were among topics explored. Techniques of group practice in a number of countries were studied.

STATE POLICE PILOTS GET MEDICAL TRAINING

A unique program sponsored
by the Pennsylvania

Department of Education in cooperation with Harrisburg Polyclinic Hospital last month provided training for state police helicopter pilots in emergency medical care reaching beyond advanced first aid courses. Ten pilots and two maintenance men received certificates for completing the initial course. They have five to six weeks of courses before them. Current courses cover chest injuries, cardiac emergencies, head and spine injuries, pulmonary emergencies, psychiatric emergencies, burn and shock management, and emergency care of fractures. The helicopter pilots have their commercial fixed pilot ratings, approximately six years of service with the state police, and are an average of 27 years old. Purpose of the program is to enable helicopters piloted by these trained men to reach accident scenes in the least amount of time, to render on-the-scene emergency aid, and to transport those injured to a hospital as quickly as possible.

ANATOMICAL GIFTS IS CONFERENCE THEME

Bryce L. Munger, M.D., chairman
of the Department of Anatomy,

and John A. Waldhausen, M.D., chairman of the Department of Surgery at the Pennsylvania State University College of Medicine, were co-hosts at a June 30 "Conference on the Ultimate Gift" held at the Milton S. Eisenhower Medical Center. Purpose of the invitational conference, which brought together interested participants from all sections of the Commonwealth, was to begin a program of education as to the need for donating bodies and body parts, and of explaining the steps to be taken in making such donations.

PMS TO SPONSOR SESSION ON RURAL HEALTH NEEDS

Physician support,
recruitment of new

doctors, financing of community health facilities, and steps to take until a doctor arrives are subjects which will be covered at a PMS sponsored statewide conference on rural health to be held on Friday, September 18, 1970, at the Penn Harris Motor Inn, Camp Hill. All leaders interested in health care problems facing rural Pennsylvanians are invited to the conference. For further information contact: Advisory Committee on Rural Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, 17043.

LACTINEX[®]

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TABLETS & GRANULES

■ to help restore
and stabilize
the intestinal flora

■ for fever blisters
and canker sores of
herpetic origin

Introduced to help reestablish the normal physiology of the intestinal tract in gastrointestinal disturbances¹, particularly diarrheas (including those resulting from antibiotic therapy), Lactinex is also useful for reestablishing the flora following bowel surgery, infant colic, mucous colitis, foul-smelling stools, pruritus ani, flatulence and hives.^{2,3,4,5,6}

Lactinex contains a viable mixed culture of both *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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Baltimore, Maryland 21201

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References:

- (1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.



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JULY, 1970

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PENNSYLVANIA MEDICINE

**Corticosteroid therapy
week after week.
then antibiotic
therapy last week.
and monilial
overgrowth this week.**

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin — it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin
where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions — urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.





decision:

Loridine[®] I.M. Cephaloridine

1.5 to 3 Gm. daily
successfully treats many
moderately severe
infections*

- bactericidal action in vitro against susceptible organisms causing:
 - pneumonias following surgery
 - abscesses
 - wound infections
 - infections following compound fractures
 - urinary tract infections
- broad-spectrum activity
- relatively painless I.M. injection
- logical I.M. follow-up to I.V. cephalosporin therapy

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



000904

Loridine[®]
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

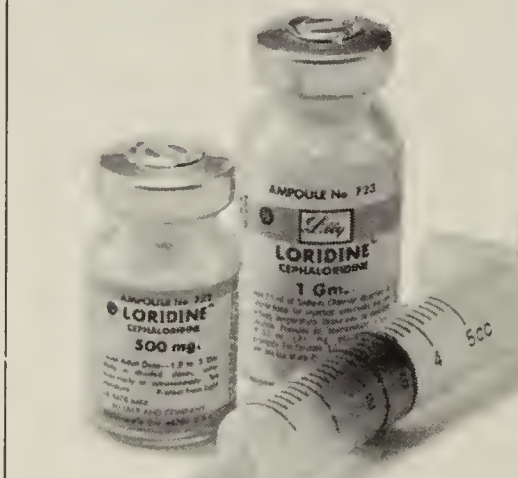
Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine® CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms, and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

Additional information
available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly



Issues, Answers, An Award

PaMPAC Takes A Look Ahead



Dr. Rial, left, does wrap-up. At the right, Dr. Lamberton accepts award for Dr. Lechner from Dr. West.

National and state issues and some answers for them were joined with a plea for grass roots political and civic activity at the semi-annual Pennsylvania Medical Political Action Committee Workshop held May 27 and 28 in Harrisburg.

Highlighting the two-day session were analyses by newsmen of the 1970 political scene on the national and state levels.

David Broder of Washington, D. C., political analyst for the *Washington Post*, spoke following the dinner May 27. His topic, "Politics 1970 — A Washington Perspective," was concerned with the history of the Indonesian conflict and its affect on American politics, and American thought.

"Political Change in Pennsylvania" was the topic of Fred Walters, news director of KYW Radio, Philadelphia, at the luncheon May 28.

Panel discussions during the two-day workshop brought political matters down to the individual level and attempted to show the need for every American to know about the issues facing the Commonwealth and the nation, and to follow his conscience in taking action to affect changes.

Among workshop participants were Ellsworth R. Browneller, M.D., Pennsylvania secretary of health; Stanley A. Miller, state secretary of welfare; William Colley of the AMA Legislative Department; Mrs. Dorothy Flechtner, director of women's activities for the U. S. Chamber of Commerce; Roger Fleming of the American Farm Bureau Federation and William R. Hunt, M.D., Allegheny County commissioner. Lieutenant Governor Raymond W. Broderick, Republican gubernatorial candidate, spoke at the opening session of the second day. His Democratic opponent, Milton J. Shapp, was unable to attend.

Among PaMPAC and PMS officers who participated were: PMS President William A. Barrett, M.D., Pittsburgh; Paul S. Friedman, M.D., PaMPAC Board Member; Edgar W. Meiser, M.D., vice-chairman, PMS Council on Governmental Affairs; William B. West, M.D., chairman of the PaMPAC Board of Directors; R. Edard Steele, M.D., PaMPAC board member, George W. Shaffer, M.D., chairman of the workshop committee and William Y. Rial, M.D., speaker of the PMS House of Delegates.

Highlight of the conference was the presentation of



Lt. Gov. Broderick, left, addresses general session, right.



honorary membership in PaMPAC, accompanied by a suitable plaque, to Carl B. Lechner, M.D., medical editor of PENNSYLVANIA MEDICINE. Dr. West made the presentation following the workshop banquet, and accepting for Dr. Lechner was William B. Lamberton, M.D., PaMPAC board member who, like Dr. Lechner, lives in Erie.

In making the presentation Dr. West said:

"On several previous occasions, PaMPAC has chosen to honor those rare individuals whose dedication to the PAC Movement has led them to commit so much of themselves to the goals of the organization as to stand out 'head and shoulders' above their fellow members.

"This is such an occasion and we honor such a rare individual. The recognition — in the form of an honorary membership — is long overdue.

"The recipient is Dr. Carl B. Lechner of Erie. His personal commitment to the PAC Movement has influenced thousands of others because he has expressed that commitment in countless editorials and articles as the Medical Editor of Pennsylvania Medicine and through the speech he prepared for the House of Delegates last fall before ill health caused him to resign as president-elect of the Pennsylvania Medical

Society. You remember that we nevertheless had the benefit of that speech because it was distributed to the house, considered by a reference committee and endorsed by the delegates. The speech was a plea by a political activist for all physicians and their families to become politically involved. He supported this theme over the years in the pages of PENNSYLVANIA MEDICINE, in his personal conversations and in public speeches.

"I am not going to recite the curriculum vitae of this general practitioner turned radiologist extraordinary, because I am sure that all of you know him and about him. His is an exemplary commitment to all of organized medicine. It ranges from service to his county and state society and the AMA to regional, state and national service in radiological groups to national leadership in the medical editor field.

"The illness that caused his resignation as president-elect to the Pennsylvania Medical Society prevents his attendance here tonight, but it has not prevented his continuing support of the various levels of the PAC Movement. We salute Carl with this plaque signifying honorary membership in the Pennsylvania Medical Political Action Committee."



Clement R. Brown, M.D. (seated) director of medical education at Chestnut Hill Hospital, Philadelphia, and Robert L. Evans, M.D., vice-president of medical affairs, York Hospital, review the results of a continuing education opinion survey conducted by Dr. Brown during the June 6 "Medical Audit in Continuing Education" workshop at Milton S. Hershey Medical Center. Over a hundred doctors, hospital administrators and medical records personnel attended the workshop, which was sponsored by the Susquehanna Valley Regional Medical Program in cooperation with the Medical Center's Department of Family and Community Medicine.

There has been a change in the Pennsylvania Medical Society's mailing address from Taylor Bypass and Erford Rd. to 20 Erford Rd. The location of the office remains the same.

Miners Get X-rays

The approximately 90,000 underground coal miners now working in the United States will be given chest x-rays, beginning about July 1, 1970, Environmental Health Service Administrator Charles C. Johnson, Jr., announced.

The mass x-ray program — authorized under the new Coal Mine Health and Safety Act — will identify those miners affected with coal workers pneumoconiosis, or "black lung." "Black lung" is a crippling, sometimes fatal respiratory disease caused by inhaling coal dust.

The proposed regulations governing the operation of the x-ray program were published today in the Federal Register. They call for the x-ray program to be completed by June 30, 1971.

"The primary purpose of this program will be to warn miners who show x-ray evidence of significant pneumoconiosis," Mr. Johnson said. "In such cases, the law provides that affected miners can be transferred from underground work to a less dusty environment to prevent the disease from becoming worse."

The x-ray program, as provided under law, will be financed by the coal mine operators. They will contract with private physicians throughout the country to take the x-rays and classify them.



DR. LECHNER

Pollution Group Chairman Named

Dr. G. Arthur Webb, Pittsburgh, has been elected chairman of the State Air Pollution Commission. A professional engineer, Dr. Webb is associate director of Mellon Institute, Pittsburgh.

Dr. Webb succeeds Dr. Allen D. Brandt, Bethlehem, who resigned from the commission in order to devote additional time to his post as manager of industrial health engineering for Bethlehem Steel Corp.

In a public ceremony Dr. Brandt was cited by Governor Raymond P. Shafer for his "years of top expertise in the air pollution control field and wonderful service to the Commonwealth."



**Fast...long-lasting
relief of aches
and pains
of colds and flu**

**with the unique
timed-release
aspirin**

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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MEASURIN[®]
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.



Charles J. H. Kraft, M.D., Meshoppen, was honored recently for ten years of service (1960-69) as a member and vice-chairman of the AMA's Council on Rural Health. Presenting the award at banquet ceremonies held in conjunction with the AMA's National Conference on Rural Health in Milwaukee, Wisc. April 9-10, 1970 is Leopold J. Snyder, M.D., Fresno, Calif. chairman, AMA Council on Rural Health.

All State Medical Schools Receive Funds

Grants in the amount of \$55,906.76 have been awarded to seven Pennsylvania medical schools by the AMA—ERF designated and undesignated funds received during 1969. These donations are a direct result of contributions from physicians, county, state and medical society treasuries, and women's auxiliaries to the medical society treasuries.

The University of Pittsburgh School of Medicine received \$8,704.62 from the foundation. The grant was accepted by the dean of the University of Pittsburgh School of Medicine, Donald N. Medearis, Jr., M.D.

The newly built Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center was presented with a \$2,591.46 grant by the foundation.

Five Philadelphia Medical Schools received grants totalling over \$44,000. Hahnemann Medical College received \$8,208.84. Jefferson Medical College of Philadelphia received \$9,023.46. \$5,121.46 was granted to the Woman's Medical College of Pennsylvania. Temple University School of Medicine was given a \$10,294.46 grant and the University of Pennsylvania School of Medicine received \$11,962.46.

PMS Represented At Pollution Meet

The Commission on Environmental Health represented the Pennsylvania Medical Society at a meeting of medical associations whose states and provinces border on the Great Lakes waterway held recently in Toronto, Ontario. Representatives from the AMA Department of Environmental Health, from the state medical associations of Michigan, Minnesota, New York, Pennsylvania, Illinois and Ohio, and from the Canadian provinces of Quebec and Ontario met to determine what means the associations might use to prevent further pollution, to educate the public to the necessity of urban and population planning in relation to water pollution, and to encourage the negotiation of a treaty between the United States and Canada to establish an international body to eradicate pollution throughout the Great Lakes drainage basin.

Pa. M.D. Honored By Psychiatrists

J. Martin Myers, M.D., who was recently named psychiatrist-in-chief of the Institute of the Pennsylvania Hospital, has received this year's E. B. Bowis Award from the American College of Psychiatrists.

The award was presented at a meeting of the college's board of regents in San Francisco. It recognizes "outstanding contributions to and/or leadership in the college." An officer of the College of Psychiatrists since 1965, Dr. Myers is currently president-elect. He will ascend to the presidency in May, 1971.

Dr. Myers was appointed to the newly created post of psychiatrist-in-chief of the Institute in April. He has been with the hospital for nineteen years, the last eight of which he served as medical director. In his new position, he is the senior executive medical authority at the Institute. He is also director designate, department of psychiatry, at Pennsylvania Hospital's sick and injured division. At the University of Pennsylvania, he has moved up to a full professorship this month.

Sports Injuries Called "Public" News

Physicians involved in the treatment of athletic injuries continue to raise questions about the ethical and legal guidelines for the release of such information to news media.

The most frequently quoted guide, established by the American Medical Association Judicial Council, says that a doctor may release only authorized information "or that which is public knowledge."

However, legal counsel for the Pennsylvania Medical Society expresses the opinion that "injuries to athletes engaged in an athletic contest, being an accident, constitute news in the public domain; that is to say, it is public knowledge, and therefore it is available for release without the patient's consent."

PMS counsel, represented by C. Grove McCown, hastened to point out that there are additional considerations including the use of individual judgment and good taste and including the fact that a team physician might be employed under an agreement that includes guidelines for the release of injury information.

Commenting on the general release of information concerning a patient, the AMA Judicial Council says, "A patient or responsible friend or relative may authorize a doctor to disclose certain health information to the press. Under these conditions, the release of information by the physician does not violate any ethical principle. However, a doctor may release only authorized information or that which is public knowledge." In another section, the Judicial Council also says in part: "Because certain news is a part of the public record . . . it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance . . . News in this category, known as news in the public domain, includes . . . accidents . . ."

Mr. McCown pointed out that the interest of the public in athletic events and injuries to the athletes participating in them is almost insatiable. He suggested that physicians in dealing with an athletic injury may encounter other

information which might tend to blacken the character of the injured athlete-patient and that certainly such information should not be released to the public without the consent of the patient.

He also pointed out that, for example, a college football team physician may have an understanding with the university's director of sports information as well as the coach and athletic director as to the time of making announcements to the press regarding injuries to any of the football players. "Even though the doctor may have an ethical right to release such information, he might be in breach of his agreement as a team physician with the university authorities," Mr. McCown pointed out.

He also noted that many leagues have rules regarding the release of information about athletic injuries.

In the absence of such rules, injuries to athletes constitute news in the public domain and therefore it is available for release without the patient's consent although individual judgment in good taste may determine the amount of information released.

State Study Reveals Errors; Changes Made in Handbook

During a proficiency test of serum electrolytes, which was conducted by the Pennsylvania Department of Health in May, 1970, several reports of serum lithium levels were found to be approximately 50 per cent lower than expected values.

Since lithium can be toxic to humans at levels only slightly above effective therapeutic concentrations, a public health danger was immediately apparent.

As a result of communications with laboratories which reported erroneous results, several discrepancies were disclosed in the methodology published in certain editions of the instruction handbook for the I. L. Flame Photometer.* These procedural discrepancies were confirmed through direct contact

with technical representatives of the Instrumentation Laboratories, Inc.

The company said it has prepared and will distribute a revision of its operating procedure for serum lithium determinations, which will incorporate the appropriate corrections. These revisions pertain to the serum sample dilution and a corrected product catalog number for their 1 mEq/l Lithium Standard.

Copies of this revised procedure are available and may be obtained by writing to the following:

Technical Services Department
Instrumentation Laboratories, Inc.
113 Hartwell Avenue
Lexington, Mass. 02173

*Instrumentation Laboratories, Inc., Watertown, Massachusetts

Phila. Immunizes

A mass immunization program against german measles was conducted during the last two weeks of May in all public and parochial schools by the Philadelphia Department of Public Health, in cooperation with the School District of Philadelphia and the Philadelphia chapter of the March of Dimes.

Free rubella vaccine was given to all children from kindergarten through fourth grade during the period of May 19 through 29 in the schools, according to Lewis D. Polk, M.D., deputy health commissioner for community health services.

City Health Department personnel performed the vaccinations, using jet injectors capable of immunizing 400 children per hour. The Health Department had 130,000 doses of rubella vaccine available for this campaign. The vaccine is also available through private physicians.



Participants at the recent annual meeting of the Pennsylvania Society of Internal Medicine held at Pocono Manor Inn were, left to right, Drs. James A. Collins, Jr., Danville, 1969-70 president; David H. Feinberg, Easton, program chairman and newly-elected president-elect; William J. Kelly, Pittsburgh, newly installed 1970-71 president and PMS trustee and William A. Limberger, West Chester, PMS president-elect. The theme of the meeting was "The Role of the Internist in Meeting the Health Needs of the Community."

Family Practice Boards Passed

Results of the first certifying examination in the new medical specialty of family practice have been revealed in an announcement by John G. Walsh, M.D., Sacramento, Calif., president of the American Board of Family Practice.

Dr. Walsh said that 81.6 per cent of the 2,078 physicians taking the test passed it successfully. The examination was offered in thirty-six centers throughout the country February 28 and March 1, 1970.

According to Dr. Walsh, the most successful of the examinees were doctors who had been graduated within the last twenty years from either United States or Canadian medical schools. Among this group, he said, 95.5 per cent passed.

Dr. Walsh said plans are now being formulated to stage a second examination in February, 1971, and noted that candidates who pass it will be included in the charter membership group of the Board of Family Practice. He added that the examination committee is preparing a completely new examination. Material used in the first exam will not be reused in the second.

Dr. Walsh said that the Board of Family Practice is unique among spe-

cialty boards because it has no "grandfather clause" which allows doctors practicing in the specialty when a board is created to become diplomates of that board without taking an examination. It is unique also, he added, because it requires recertification by examination at six-year intervals to maintain membership status.

As with other specialty boards, the principal functions of the Board of Family Practice are to provide a certifying examination and testing and grading facilities, and to grant certification. The initial examination was prepared by a special committee of the AAGP working in conjunction with the National Board of Medical Examiners, with final preparation and staging phases being directed by the Board of Family Practice. The National Board of Medical Examiners is a private, non-profit agency whose function is to design examinations and testing procedures for medical specialty boards and licensing agencies.

Headquarters of the Board of Family Practice is at the University of Kentucky Medical Center, Lexington, under direction of Dr. Nicholas J. Pisacano, secretary-treasurer of the Board.

State Aids 60,000 In Medical Need

Nearly 60,000 Pennsylvania children were provided medical services through State Health Department programs during the 1968-69 fiscal year.

Under the State's Child Health Conferences, conducted under the director of the Health Department's Division of Maternal and Child Health, nearly 30,000 children received health supervision services.

The child health conference operates to provide free medical supervision for pre-school age children who are not under the care of a private physician or otherwise receiving health supervision.

Under several other programs, also directed by the Division of Maternal and Child Health, 30,948 handicapped children in Pennsylvania were provided medical care.

These figures include the clinic and hospital care provided at the State Hospital for Crippled Children, Elizabethtown, which offered clinic services to 2,307 last year and hospital care to 328.

Other programs, through which care was provided to handicapped children included: cardiac, speech and hearing, orthopedic, cleft palate-plastic surgery, neuromuscular, phenylketonuria, neonatal surgery and the cystic fibrosis programs.

More than 8,000 children received care under the State's orthopedic program, which provides for pediatric, orthopedic examinations, x-rays, braces, surgery, artificial limbs and other related services.

During the last fiscal year nearly 8,000 children received treatment and diagnostic care under the state's speech and hearing program, while more than 3,000 Pennsylvania children were seen at the State cardiac clinics for the diagnosis and treatment of various heart disorders.

Charges for services to handicapped children, under 21 years of age, are based on the families' ability to contribute to costs.

Population Problem Theme of Congress

"The Population Problem and the Physician" was the theme of the 1970 AMA Congress on Environmental Health last month in Washington, D. C.

The agenda included papers and discussions on population control in both the U. S. and throughout the world, family planning programs, the medical and clinical aspects of fertility control, the role of the health services, and legislative and governmental activities in this area.

Registrants included an audience representing medicine, medical education, public health, social work, nursing, family planning, government and other organizations and individuals concerned with population growth.

One of the distinguished guests was Roger O. Egeberg, M.D., assistant secretary of the Department of Health, Education, and Welfare. His subject was: "Toward a Population Policy for the United States."

Population in relation to socioeconomic developments, health and environmental factors, food supply, pollution, urbanization and racial tensions was studied, as were family planning programs, both private and governmental, contraceptive practices and fertility control.



Park M. Horton, M.D., chairman of the PMS Board of Directors conducted a shirtsleeves session of the board at the May 13 meeting at King's Gap. The board at work is shown above.

In the top right picture, PMS Executive Director John F. Rineman receives a fifteen-year award from Dr. Horton during the proceedings. At the bottom, right, David S. Masland, M.D., Carlisle, host for the meeting, and Dr. Horton enjoy the view from King's Gap, in the hills of Cumberland County.



Conrad Etzel, M.D., president of the Delaware County Medical Society, discusses some of the points presented in an exhibit at "Delco Day," a county-wide health fair held in Ridley Township. The exhibit was cosponsored by the county society and the Pennsylvania Medical Society and told how medical societies serve the public.

VA Seeks Vietnam Veterans To Fill Hospital Vacancies

Veterans Administration hospitals are making a special effort to attract Vietnam veterans to fill hospital staff vacancies as doctors and nurses, and to work in thousands of sub-professional positions.

Administrator of Veterans Affairs Donald E. Johnson said that almost 6,000 veterans with medical skills were hired by VA hospitals during 1968 and 1969. Recruiting will be even more vigorous during 1970, Johnson said, because VA's department of medicine and surgery now has the largest personnel authorizations in its history.

President Nixon's budget request for VA in fiscal year 1971 will increase the VA medical care staff by 5,723 employees, raising full-time employment to 137,856 — the biggest work force in the department's history.

"Men and women who have learned new skills in military service are a valuable national resource," Johnson said, "and this is true especially of those who have been trained in the medical field. There are thousands of job vacancies in the health care field and jobs are being created faster than people are being trained."

**FIGHT
CANCER**



From representatives of two organizations in the cancer control field come words of tribute for two humanitarians. From the left: Mr. and Mrs. Morris W. Satinsky, Villanova, are presented with the 1970 Humanitarian Award of the American Cancer Society by Jonathan E. Rhoads, M.D., national president of ACS, and president of the Philadelphia County Medical Society, and Frank E. Adair, M.D., executive officer of the Memorial Sloan Kettering Cancer Center, New York, N. Y. Mr. and Mrs. Satinsky were honored at the 22nd annual luncheon of the Kain Moses Group for Cancer Research, which raised over \$100,000 in its 1970 advance gifts drive for the American Cancer Society.

President Honors Elwyn's Dr. Clark

Gerald R. Clark, M.D., of Elwyn, Pennsylvania, was named physician of the year today by the President's Committee on Employment of the Handicapped.

The award, a cooperative presentation by the committee and the American Medical Association, is the nation's highest tribute to physicians for their contributions to the welfare and employment of the handicapped. Earlier this year Dr. Clark was honored by the Commonwealth when Gov. Raymond P. Shafer named him Pennsylvania physician of the year.

Long active in the fields of mental illness and rehabilitation, Dr. Clark served as the first commissioner of mental retardation for the Commonwealth.

After starting with the Public Health Service, Dr. Clark served on the staffs of several state hospitals before becoming superintendent of Elwyn Institute in 1960. He is currently the president.

Pitt Medical School Granted \$5 Million

The University of Pittsburgh School of Medicine has received \$5,000,000 from the Richard King Mellon Charitable Trusts, in the form of a grant, for further strengthening the Department of Psychiatry at the School. Announcement of the grant was made today by Chancellor Wesley W. Posvar. The grant, a major portion of which is in the form of endowment to support outstanding faculty, will be payable over a five-year period. Financial resources for such programs are not available from federal or state sources.

The Mellon letter of transmittal stated:

"The trustees of the Richard King Mellon Charitable Trusts have become increasingly concerned with the problem of mental health. In an age when tension and its ensuing debilitation are increasing rapidly, the trustees have been exploring ways in which charitable funds can make the best contribution

to the field of mental health. With alcoholism, drug abuse and mental disorders increasing at a rapid rate, and research in child psychiatry progressing to a stage where adequate treatment can be performed, it is important that the trustees support the educational, research and treatment aspects of psychiatry."

When Donald N. Medearis, Jr., M.D., became dean of the school of medicine last September, he indicated that one of the areas to be assigned the highest priority would be development of programs in the psychiatric and behavioral sciences. In acknowledging the grant he said, "This gift from the Mellon Charitable Trusts will contribute substantially to the school's ability to create an environment in which education, treatment and research can flourish in the department of psychiatry and in the Western Psychiatric Institute and Clinic (WPIC), and should enable the

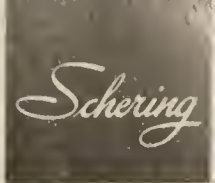
school to recruit an outstanding successor to Dr. Henry Brosin who retired as professor and chairman of the Department of Psychiatry and director of WPIC last summer."

Pitt Graduates M.D.'s

Commencement exercises honoring ninety-five graduating seniors of the University of Pittsburgh School of Medicine were held May 28.

Diplomas were awarded by Dean Donald N. Medearis, M.D., in Schenley Hall on Pitt's campus.

Participating in the ceremonies were Associate Deans A. E. Axelrod, M.D., and Samuel P. Harbison, M.D. Closing remarks were delivered by F. S. Cheever, M.D., vice chancellor for the health professions. Faculty Marshal Paul L. McLain, M.D., and Class Marshal John S. Beachler led the processional.



After only one year:
Administered
to more people
than live in
Erie and
Harrisburg.*



Injectable
Garamycin[®]
brand of gentamicin sulfate
injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Erie and Harrisburg is 207,000.
(Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections^{1,2}

GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections³

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving⁴⁻⁶

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.⁶



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis⁷

The established efficacy of GARAMYCIN Injectable against *Pseudomonas* — as well as most other gram-negative pathogens — makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.

In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, **every** gram-negative culture slip from **every** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested		Antibiotics*					
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
<i>Klebsiella pneumoniae</i>	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
<i>Aerobacter aerogenes</i>	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
<i>Klebsiella aerobacter</i> group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
<i>Klebsiella</i> , all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
<i>Pseudomonas aeruginosa</i>	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
<i>Proteus</i> , indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
<i>Proteus mirabilis</i> , indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
<i>Proteus</i> , unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
<i>Escherichia coli</i> and all other <i>Escherichias</i>	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
<i>Paracolobactrum</i> , all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
<i>Colliform bacteria</i>	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070

Gram-positive (Included for consistency with Package Insert, not an approved indication)

Staph— <i>S. aureus</i> , coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph— <i>S. aureus</i> , unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).^a Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.

Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.

Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.

It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable
Garamycin[®]
brand of
gentamicin sulfate
injection

See Clinical Considerations section on last page...

Injectable Garamycin[®] gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	Less Severe 0.8-1.2 mg./kg. for 7-10 days	Resistant/ Moderately Severe Larger doses or additional antibac- terial therapy should be consid- ered in severe urinary tract infec- tions or in resistant cases involving the renal parenchyma or anatomic anomaly.	Serious/Life- Threatening
Other Infections including bacter- emia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		up to 5 mg./kg.

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by:				No. of In Vitro Studies
		4 mcg./cc. or less	(%)	8 mcg./cc. or less*	(%)	
<i>Staphylococcus aureus</i>	1,210	1,200	(99%)	1,206	(99%)	11
<i>Pseudomonas aeruginosa</i>	885	771	(87%)	828	(93%)	16
<i>Escherichia coli</i>	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative <i>Proteus</i> species	477	210	(44%)	358	(75%)	12
<i>Klebsiella-Aerobacter</i> species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa*, 828 (93%); *Escherichia coli*, 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.

Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa*, *Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Schering

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, *Arch. Int. Med.* 114:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, *J. Infect. Dis.* 119:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, *J. Infect. Dis.* 119:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in *Gentamicin: First International Symposium*, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, *J. Infect. Dis.* 119:533, 1969. (7) Polk, H.: Discussion, *J. Infect. Dis.* 119:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

Dr. Barrett Tells Auditor General:

"Keep the Tar Brush in the Bucket"

In testimony last month before the House of Representatives Appropriations Committee, Auditor General Robert P. Casey indicated he is "much concerned" about doctors submitting duplicate bills in federal and state medical programs. He said his department is investigating doctors bills after the committee asked him about the probe of alleged fraudulent practices in the relief office.

In response to the allegations, PMS President William A. Barrett, M.D., sent the following letter to the auditor general, and issued copies to the press:

June 4, 1970

The Honorable Robert P. Casey
Auditor General
Commonwealth of Pennsylvania
Finance Building
Harrisburg, Pennsylvania

Dear Mr. Casey:

In all probability, most if not all of the physicians you maligned yesterday before the House Appropriations Committee with your innuendo that they have been fraudulently submitting duplicate bills have done nothing more than attempt to get paid once for the work they have performed — and at less than usual fees, at that.

Was your claim that doctors are submitting duplicate bills in state medical programs based on the fact that doctors often must submit second, third and more notices because the first billing was not paid?

Or did you really mean that many physicians fraudulently are attempting to get paid twice for the same procedure?

If the latter is true, the Pennsylvania Medical Society repeats an urging that it has made on fourteen previous occasions to branches of state government — an urging that any evidence of fraud by medical doctors be shared with the medical society so that it can take disciplinary action in any proven instance to prevent any reoccurrence. Despite these urgings, the Pennsylvania Medical Society has never received from any branch of state government evidence of fraudulent practices by any of its members.

However, if your statement was based on the fact that all of those who supply services under state government programs usually must submit multiple billing notices before even a single payment is received, you have been grossly unfair in creating the impression that additional notices of request for payment constitute an attempt to be paid two or more times for the same services.

You should be aware that the state government's procedures for making payment to those who supply medical and other services may be at fault. For example, checks sent to physicians and others under state medical programs

bear no information about the service for which payment is being made. Unless the amount of the check precisely matches the amount of a previous bill submitted by a physician, the physician has no way of knowing for which services he is being reimbursed. What's more, departments frequently make modifications in the physician's bill. When the amount of the check differs from the amount of the physician's bill, the physician has no way of knowing whether the check is payment for services rendered two months ago or six months ago and if he is to receive any payment, he has no alternative but to submit second, third and even more notices of particular bills.

We have been urging for several years that the procedures be changed but if state government has no way of knowing whether or not a particular bill has been paid and thus on occasion makes a duplicate payment, cast your innuendo at those responsible for the procedures and not at the physician because the physician may have no hint that he has been paid twice for the same procedure until the end of the year when an audit of all of his state government billings is compared to the total of the checks he has received.

We have urged time and time again that sound fiscal and record keeping procedures be established so that a check to a physician will indicate the services that it covers and thus save taxpayers — including physicians — many unresolved headaches.

On the other hand, if your comments about physicians' duplicate billings were nothing more than your joining the bandwagon of heaping abuse on physicians for the inadequacies of ill-conceived programs and procedures, we are disappointed.

If "fraud" exists, Mr. Casey, root it out and prosecute and you'll find that we will help in any way that we can if fraud involves one of our physician members. If fraud is nothing more than a suspicion, we urge you to keep the tar brush in the bucket until you get all of the facts.

Sincerely,

William A. Barrett, M.D., President
Pennsylvania Medical Society

Interspecialty Committee Holds First Meeting

The Interspecialty Committee of the Pennsylvania Medical Society held its organizational meeting June 3 at PMS Headquarters. Representatives of seventeen specialty societies in Pennsylvania attended the meeting at which Park M. Horton, M.D., chairman of the PMS Board of Trustees, presided.

PMS President William A. Barrett, M.D., opened the meeting with welcoming remarks. Past President George E. Farrar, Jr., M.D., spoke to delegates about the history of the need for such a committee of the PMS Board of Trustees. Delegates were introduced by PMS President-Elect William A. Limberger, M.D.

Following a discussion of each group's specific problems, delegates voted to meet again during the Annual Scientific Assembly at Host Farm Resort Motel on Wednesday, Nov. 18, 1970.

Robert S. Pressman, M.D., Philadelphia, delegate from the Pennsylvania Society of Internal Medicine, was elected committee chairman, and Leonard F. Bush, M.D., Danville, was chosen vice-chairman. Dr. Bush represents the American College of Surgeons in Pennsylvania.

Following is a list of delegates in attendance:

Pennsylvania Society of Anesthesiologists

Louis J. Hampton, M.D.
300 Highland Ave.
Hanover, Pa. 17331

The Pennsylvania Society of Colon and Rectal Surgery

Guy L. Kratzer, M.D.
1447 Hamilton St.
Allentown, Pa. 18102

Pennsylvania Academy of Dermatology

Herbert Goldschmidt, M.D.
1 Decker Square
Bala Cynwyd, Pa. 19004

Pennsylvania Academy of General Practice

Thomas L. Leaman, M.D.
Hershey Medical Center
Hershey, Pa. 17033

Pennsylvania Society of Internal Medicine

Robert S. Pressman, M.D.



Participants at the fourteenth biennial meeting of the Association of Geisinger Physicians were, front row, left to right, Drs. Valentine F. Pytko, member of the planning committee; E. McG. Hedgpeth, president; Jack Longacre and Joseph Schatanoff, guest speakers. Back row, Drs. Harold E. Brown, chairman of planning committee; John Schneider, president-elect, and Leonard F. Bush, chief of staff, Geisinger Medical Center.

170 West Olney Ave.
Philadelphia, Pa. 19120

Philadelphia Neurosurgical Society
Stuart N. Rowe, M.D.
3600 Forbes St.
Pittsburgh, Pa. 15213

American College of Obstetricians and Gynecologists

Harold M. Cohen, M.D.
3400 Forbes Ave.
Pittsburgh, Pa. 15213

Pennsylvania Academy of Ophthalmology and Otolaryngology

William K. Grove, M.D.
426 Market St.
York, Pa. 17404

Otolaryngology

David A. Cope, M.D.
210 S. 6th Ave.
West Reading, Pa. 19602

The Pennsylvania Orthopaedic Society

Robert H. Cram, M.D.
49 Hamden Rd.
Upper Darby, Pa. 19082

Pennsylvania Association of Clinical Pathologists

Robert C. Lyons, M.D.
1759 Helen Dr.
Pittsburgh, Pa. 15216

Pennsylvania Academy of Physical

Medicine and Rehabilitation

Thomas C. Hohmann, M.D.
St. Francis General Hospital
Pittsburgh, Pa. 15201

Pennsylvania Psychiatric Society

Frederick L. Weniger, M.D.
3811 O'Hara St.
Pittsburgh, Pa. 15213

American College of Surgeons in Pennsylvania

Leonard F. Bush, M.D.
Geisinger Medical Center
Danville, Pa. 17821

The Pennsylvania Association of Thoracic Surgery

Benjamin G. Musser, M.D.
2247 Front St.
Harrisburg, Pa. 17110

Urological Association of Pennsylvania, Inc.

Josiah F. Reed, Jr., M.D.
508 N. Second St.
Harrisburg, Pa. 17101

Pennsylvania Radiological Society

Ross H. Smith, Jr., M.D.
265 46th St.
Pittsburgh, Pa. 15201

Theodore A. Tristan, M.D. of Harrisburg Polyclinic Hospital also attended the meeting.

**I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.**



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine,

mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand

and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and enuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.



Photo professionally posed.



**I'll scream
if I don't get away!**

Official Call to the Annual Session of the House of Delegates



The 1970 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in the Baroque Ballroom of the Host Farm Motel, Lancaster, Pennsylvania at 7:30 p.m., Monday, October 5, 1970. Subsequent meetings of the House of Delegates are scheduled for 9:00 a.m., Wednesday, October 7, and 9:00 a.m., Thursday, October 8.

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Printed below is the text of the amendments to the Constitution and By-laws which are being proposed by the Committee on Constitution and By-laws.

Note: Material which is underscored is being added. Material which is enclosed in [brackets] is being deleted.

1. Subject: Amendment of membership provisions to create a separate class of membership for Interns and Residents with the right to vote and hold office, and with preferential treatment regarding dues.

CONSTITUTION ARTICLE IV – MEMBERSHIP

Amend Article IV as follows:

Amend subsection (e) of Section 5 as follows:

“(e) physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, public health, or administrative medicine, [or hospital residency,] and”

Insert a new Section 6 in front of the current Section 6, the new Section 6 to read as follows:

“Section 6. Intern and Resident Members – Intern and Resident Members shall be persons serving an internship or a hospital residency in an accredited hospital in Pennsylvania. Neither Intern nor Resident Members shall be required to pay any annual assessment.”

[Section 6] amend to become Section 7.

[Section 7] amend to become Section 8.

[Section 8] amend to become Section 9.

ARTICLE XI – FUNDS

Amend Section 1 as follows:

“Section 1.—Annual Assessment—Money for the purposes of the Society . . . except that the annual assessment for those [(a) serving hospital residencies or engaged in other forms of recognized full-time postgraduate training shall,

during the period of such training, be 10 per cent of the regular annual assessment, provided the Component Society of which each is a member grants a corresponding reduction in its annual assessment, (b)] (a) serving temporarily in the Armed Forces . . . after March 1, and [(c)] (b) prevented from the practice . . . annual assessment. No annual assessment shall be payable by an Associate, Affiliate, Intern or Resident, Special Student*, or Honorary Member. . . .” (*The words “Special Student” were inserted to correct an oversight in 1969.)

BY-LAWS CHAPTER I – MEMBERSHIP

SECTION 3 – ADMISSION TO MEMBERSHIP.

At the end thereof add the following:

“Every member of a Component Society eligible to become an Intern or Resident Member of this Society shall become such upon receipt by the Executive Director of the certification required by Section 4 of Chapter XVI of these By-laws.”

Amend as follows:

“In addition to the limitations . . . in these By-laws, neither Associate [nor] , Affiliate, Intern or Resident, or Special Student* Members, unless . . . established by this Society, and Affiliate, Intern or Resident, or Special Student* Members shall not be . . . established by this Society.” (*The words “Special Student” are inserted to correct an oversight in 1969.)

CHAPTER XVI – COMPONENT SOCIETIES

SECTION 4 – Membership Records.

At the end of the third sentence add:

“. . . Constitution [.] , or (e) in the case of Intern or Resident Members, certifying that the member possesses the qualifications of such membership set forth in Section 6 of Article IV of the Constitution. The secretary . . . after their election.”

II. Voting Rights for Associate Members

Amend the Constitution, Article IV, Section 8, as follows:

“Section 8 – Rights and Privileges of Members including Voting Rights. All member of this Society . . . except that neither [Associate nor] Affiliate nor Honorary Members . . . , or commission.”

Amend the By-laws, Chapter XIV, Section 1, subsection (d), as follows:

“(d) Qualification for Membership on Committees, Administrative Councils and Commissions. All members of this Society, except [Associate,] Affiliate [and], Honorary and Special Student* Members shall be eligible to serve as members of committees, administrative councils and commissions except that.” (*The words “Special Student” are inserted to correct an oversight in 1969.)

III. Subject: Sturgis Standard Code of Parliamentary Procedure.

Amend Chapter III, Section 6 of the By-laws as follows:

“Section 6 – Rules of Order. [Robert’s Rules of Order, Revised] Sturgis Standard Code of Parliamentary Procedure, Second Edition, shall govern the proceedings of the House of Delegates unless otherwise provided in the Constitution or these By-laws.”

IV. Subject: Clarifying Amendments concerning Affiliate and Honorary Members who are missionaries.

Amend Subsection (b), Section 5, Article IV of the Constitution as follows:

“(b) American physicians, whether or not licensed to practice medicine and surgery in the Commonwealth, who are engaged in missionary or philanthropic labors.”

Amend (old) Section 6 (new Section 7) of Article IV of the Constitution as follows:

“Section 6 – Honorary Member. Any physician, whether or not holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania, not a resident of Pennsylvania . . . annual assessment.”

V. Subject: Amendment to By-laws to allow a chairman of a council, commission or committee to be reappointed for three terms regardless of his tenure on the council, commission, or committee, as follows:

CHAPTER XIV – COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS.

Section 1 – Appointment of Members, Vacancies and Qualification.

(subsection) (d) Qualification for Membership on Committees, Administrative Councils and Commissions.

“(iv) No member of an administrative . . . to have served a term. Notwithstanding any other provisions in these By-laws, any member of this Society appointed chairman of any committee, commission or council may serve in that office up to three consecutive terms. For the purposes . . . to have served a term.”

The following amendments to the Constitution and By-laws are proposed by fifteen active members of the Beaver County Medical Society.

I. Subject: Rescission and elimination of seating and voting rights in the House of Delegates of the President of each Student American Medical Association Chapter in Pennsylvania, and rescinding and eliminating also their rights to serve on reference committees and introduce resolutions.

**CONSTITUTION
ARTICLE IV – MEMBERSHIP**

[Section 7 – Special Student Member.

The President of each Active Chapter of the Student American Medical Association in the medical schools of the Commonwealth of Pennsylvania shall be a Special Student Member. Special Student Members shall not be required to pay any annual assessment.]

Section 8 shall become Section 7 and shall be further amended as follows:

Section 8 – Rights and Privileges of Members, including Voting Rights.

All members of the Society shall have all of the rights and privileges of membership except as otherwise provided in this Constitution and the By-laws and except that neither Associate nor Affiliate nor Honorary Members shall have the right to vote or hold any office or to be members of any council, committee, or commission.

[Each Special Student Member shall serve as a delegate in the House of Delegates with the right to vote and to serve on reference committees, with the exception of the Reference Committee on Constitution and By-laws; but no Special Student Member shall have the right to hold any office or to be a member of any council, commission, or committee.]

No member of this Society of any class shall have any direct vote in the affairs of this Society except as to such matters, if any, where such vote is required by the laws of the Commonwealth of Pennsylvania.

Section 9 shall become Section 8.

ARTICLE VI – HOUSE OF DELEGATES

Amend Section 2 as follows:

Section 2 – Composition.

The House of Delegates shall be composed of (a) delegates (or their alternates) elected by the Component Societies in the proportion of one delegate for every one hundred or fraction thereof of its Active and Senior Active Members in this Society whose dues are paid or excused as of December 31 of each preceding year, whose term of office shall be for a term of one year or for a term in excess of one year if such Component Society’s By-laws provide for a longer term than one year provided that at least one delegate or alternate be elected by such Component Society each year, and whose names have been submitted to the office of the Executive Director of the Pennsylvania Medical Society as instructed by the Executive Director, and in January of each year the Executive Director of the Pennsylvania Medical Society shall certify to each Component Society the number of delegates to which it is entitled during the current year; (b) the secretaries of the Component Societies in office at the time of any meeting of the House of Delegates; [(c) special student members (or their alternates) as defined in Sections 7 and 8 of Article IV; and (d)] (c) ex-officio, but without the right to vote, the Speaker and Vice-Speaker of the House of Delegates, the President, President-Elect, the Vice-Presidents, the Secretary, the Trustees and Councilors, and the member of the Judicial Council of this Society, the ex-presidents of this Society and the presidents of the Component Societies, except that any of the foregoing ex-officio delegates, other than those

prohibited from so doing by Article V of this Constitution, may at the same time serve as voting delegates duly designated as such by the respective Component Societies, and except that the Speaker, or the Vice-Speaker when serving as Speaker, shall have the right to vote in all cases where his vote would change the result of a vote taken other than a vote decided by ballot.

Eliminate Section 3, paragraph four.

[If any special student member is unable to serve he may designate an alternate to serve in his place from the active membership of his Chapter of the Student American Medical Association.]

BY-LAWS

CHAPTER III – HOUSE OF DELEGATES

Amend Section 4 by eliminating second sentence as follows:

Section 4 – Credentials of Delegates.

Prior to the opening of any session of the House of Delegates, each voting delegate and each alternate delegate shall deposit with the Committee on Credentials a certificate signed by the President and Secretary of the Component Society, or any two officers thereof duly authorized by its governing board to sign such certificates, under the seal of the same, stating that he has been legally and regularly designated as a voting delegate or alternate delegate to this Society. [Each Special Student Member or his alternate shall deposit with the Committee on Credentials a certificate signed by the Secretary of this Society under the Society's seal which states that he is the duly certified representative of his Chapter of the Student American Medical Association.]

ELECTIONS

Among the general officers to be elected by the 1970 House of Delegates will be:

A President-Elect, four Vice-Presidents, a Secretary, a Speaker of the House of Delegates, and a Vice-Speaker of the House of Delegates.

A Trustee and Councilor for the Third Councilor District, to serve for five years, to succeed Ralph K. Shields, M.D., Northampton County, who is eligible for reelection, having served two years of the unexpired term of Joseph A. Walsh, M.D., Lackawanna County.

A Trustee and Councilor for the Ninth Councilor District, to serve for five years to succeed Cyrus B. Slease, M.D., Armstrong County, who is eligible for reelection having served one term of five years.

Also to be elected for a two-year term beginning January 1, 1971 will be six delegates and six alternate delegates to the American Medical Association.

Delegates whose terms expire December 31, 1970 are:

William A. Barrett, M.D., Allegheny County
Park M. Horton, M.D., Susquehanna County
Edmund L. Housel, M.D., Philadelphia County
William A. Limberger, M.D., Chester County
William Y. Rial, M.D., Delaware County

William B. West, M.D., Huntingdon County

Alternates whose terms expire December 31, 1970 are:

R. William Alexander, M.D., Berks County
A. Reynolds Crane, M.D., Philadelphia County

Leo C. Eddinger, M.D., Lehigh County
Raymond C. Grandon, M.D., Dauphin County
George A. Rowland, M.D., Columbia County
R. Robert Tyson, M.D., Philadelphia County

Also to be elected will be a member to serve for three years on the Committee to Nominate Delegates and Alternates to the American Medical Association to succeed Daniel H. Bee, M.D., Indiana County, whose term expires and who is eligible to succeed himself.

Also to be elected will be one member of the Judicial Council to serve for a term of five years to succeed H. Malcolm Read, M.D., York County, who is ineligible to succeed himself. As directed by Article IX, Section 5 of the Constitution, the Board of Trustees nominates the following members for the vacancy on the Judicial Council: M. Louise C. Gloeckner, M.D., Montgomery County, Clarence J. McCullough, M.D., Washington County, and Frederick W. Ward, M.D., Northampton County.

Also to be elected is a District Censor from each component county medical society to serve for one year following the close of the 1970 House of Delegates' session.

The component county medical societies have submitted the following nominations for District Censor:

Adams, James H. Allison; Allegheny, Robert A. Schein; Armstrong, Arthur R. Wilson; Beaver, Herman Bush; Bedford, James K. Gordon; Berks, Eugene Mendelsohn; Blair, John W. Hurst; Bradford, Willis W. Redding; Bucks, Stanley F. Peters; Butler, Earl L. Mortimer; Cambria, Warren F. White; Carbon, James M. Steele; Centre, H. Richard Ishler; Chester, Grant W. Bamberger; Clarion, Theodore R. Koenig; Clearfield, Fred Pease; Clinton, George J. Treires; Columbia, G. P. Moser; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Hamblen C. Eaton; Delaware, Edward G. Torrance; Elk-Cameron, James L. Hackett, Sr.; Erie, Robert L. Loeb; Fayette, Othello S. Kough; Franklin, Albert W. Freeman; Greene, W. W. Bartholomew; Huntingdon, Frederick H. Steele; Indiana, Samuel Cohen; Jefferson, Franklin S. Bizousky; Lackawanna, John C. Sanner; Lancaster, William A. Atlee; Lawrence, Gerald H. Weiner; Lebanon, C. Raymond Bell, Jr.; Lehigh, Frederick R. Bausch, Jr.; Luzerne, Donald F. Closterman; Lycoming, Wilfred W. Wilcox; McKean, Ralph Hockenberry; Mercer, Robert E. Sass; Mifflin-Juniata, John R. Hunter, Jr.; Monroe, Claus G. Jordon; Montgomery, Rudolph K. Glocker; Montour, Isaac L. Messmore; Northampton, Walter J. Filipek; Northumberland, J. Mostyn Davis, Jr.; Perry, Frank A. Belmont; Philadelphia, Charles M. Thompson; Potter, H. C. Mosch; Schuylkill, Joseph T. Marconis; Somerset, Alexander Solosko; Susquehanna, Raymond C. Davis; Tioga, James W. Montague; Union, John S. Purnell, Sr.; Venango, George S. Smith; Warren, Donald J. Furman; Washington, Herbert J. Levin; Wayne-Pike, Howard R. Patton; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, William C. Langston.

This Call to the Annual Session of the House of Delegates has been issued this First day of July, 1970.

Raymond C. Grandon, M.D.
Secretary



E. Howard Bedrossian, M.D., associate professor of clinical ophthalmology at the University of Pennsylvania College of Medicine, recently published a second book on ophthalmology entitled, "The Surgical and Nonsurgical Management of Strabismus." It has been published by Charles C. Thomas, Publishers, Springfield, Ill. Dr. Bedrossian also presented a surgical film, "Intrasheath Tenectomy of the Superior Oblique," at the International Congress of Ophthalmology meeting in Mexico City in March.

William A. Sodeman, M.D., Rosemont, has become executive director of the newly formed Commission on Foreign Medical Graduates. Based in Philadelphia, the commission has been established with the support of leading health organizations to improve medical education standards and levels of practice of foreign medical graduates and to provide information which may be helpful to other countries in their systems of medical education and care.

William F. Donaldson, M.D. clinical professor of orthopaedic surgery, University of Pittsburgh School of Medicine, was elected secretary of the American Academy of Orthopaedic Surgeons at the group's annual meeting recently. Dr. Donaldson is a member of the senior orthopaedic staff of Presbyterian-University, Children's, St. Francis, Western Pennsylvania, and St. Margaret Memorial hospitals, all of Pittsburgh. He is president of the Allegheny County Medical Society.

Mark A. Stewart, M.D., a child psychiatrist unique in his field because of achievements as both a clinical and basic research scientist has been named the first professor and chairman of psychiatry in the College of Medicine at Milton S. Hershey Medical Center of Pennsylvania State University. Dr. Stewart is the author of forty scientific articles, and has made significant contributions in the treatment of hyperactive children and research of the genetic origin and natural history of that syndrome in children and their families. He comes to Hershey this month from Washington University School of Medicine, St. Louis, Mo.

James A. Rock, M.D., chairman of the Western Pennsylvania Regional Medical Program Advisory Committee has named **Jack D. Myers, M.D.**, chairman, department of medicine, University of Pittsburgh School of Medicine, to chair its committee on heart disease.

Harry S. Goldsmith, M.D. has been appointed the Samuel D. Gross professor of surgery and chairman of the department of surgery, Jefferson Medical College, Thomas Jefferson University. The announcement was made by **William F. Kellow, M.D.** dean and vice-president.

William A. Sodeman, M.D., of Philadelphia, was installed president of the American College of Cardiology at its Annual Scientific Session held recently in New Orleans, La.

Joseph W. Spelman, M.D. medical examiner for the city of Philadelphia, has been elected president of the National Association of Medical Examiners for the term 1970-1971.

At the annual meeting of the American Academy of Forensic Sciences held in Chicago, Illinois recently, **Cyril H. Wecht, M.D.**, Allegheny County coroner, was elected to the position of president-elect. Dr. Wecht, 38, is the youngest man ever to be elected to this position in the academy.

The appointment of **David B. Baird, M.D.**, as an assistant in the department of cardiovascular surgery at the Geisinger Medical Center, has been announced by **Leonard F. Bush, M.D.**, chief of staff. Dr. Baird had been in the private practice of general surgery in Pottsville.

Two Harrisburg physicians have received basic science faculty appointments in the College of Medicine at Milton S. Hershey Medical Center of Pennsylvania State University in recognition of their volunteer teaching services. Named as lecturers in anatomy are **Joseph B. Bittenbender, M.D.**, and **Lewis T. Patterson, M.D.** They join four area physicians who received similar appointments in previous years: **Robert P. Dutlinger, M.D.**, Harrisburg, **John H. Harris, Jr., M.D.**, Carlisle, **Richard J. Patterson, M.D.**, and **Theodore H. Tristan, M.D.**, both of Harrisburg.

Robert J. Beitel, Jr., M.D., Allentown, was installed as president of the Pennsylvania Academy of Ophthalmology and Otolaryngology, at its annual convention, to serve a one-year term. Dr. Beitel succeeds retiring president, **H. Ford Clark, M.D.**, Huntingdon. **Joseph P. Atkins, M.D.**, Philadelphia, was chosen president-elect to take office in 1971.

Joseph Medoff, M.D., has been appointed professor of clinical medicine at Jefferson Medical College, Thomas Jefferson University. A Jefferson alumnus, Dr. Medoff received the Lindback Foundation Award for Distinguished Teaching at his alma mater in 1967. An eminent gastroenterologist, he is also a member of several executive committees of the medical college and hospital.

David E. Kuhl, M.D., of Rosemont has received the fellowship degree of the American College of Radiology. The award was presented during the ACR annual meeting. He is affiliated with the Hospital of the University of Pennsylvania.

Joseph Stokes, Jr., M.D., Philadelphia, emeritus physician-in-chief at Children's Hospital of Philadelphia, spoke before the king and queen of Denmark and an audience of 800 recently, when he delivered the first Thorvald Madsen Lecture at the University of Copenhagen.

David L. Nahrwold, M.D., has been appointed associate professor of surgery in the College of Medicine at Milton S. Hershey Medical Center of Pennsylvania State University. Since 1968 he has been an assistant professor of surgery at Indiana University, Bloomington, Ind.

W. Paul Havens, Jr., M.D., Philadelphia, clinical professor of microbiology and professor of medicine, Jefferson Medical College, Thomas Jefferson University, has been awarded the outstanding civilian service award by the Armed Forces Epidemiological Board. The medal and citation were awarded for his continuous service on the board's Commission on Viral Infections and the Commission on Liver Diseases.

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Hugo Dunlap Smith, M.D., formerly professor of pediatrics at the University of Cincinnati College of Medicine, has been named associate dean for curriculum of Temple University School of Medicine. He resides in Chestnut Hill.

James Robert Leonard, M.D., has been appointed professor and chairman of the department of otolaryngology, Jefferson Medical College, Thomas Jefferson University. The announcement was made by **William F. Kellow, M.D.**, dean and vice-president. Dr. Leonard comes to Jefferson from the University of Iowa School of Medicine.

Richard A. Kern, M.D., Philadelphia, was honored recently at the seventy-fifth anniversary meeting of University Lodge No. 610, F&AM. He is a past master of the lodge.

Louise J. Sabol, M.D., has been appointed an associate in the department of ophthalmology at the Geisinger Medical Center, Danville, according to an announcement by **Leonard F. Bush, M.D.**, chief of staff.

Horatio T. Enterline, M.D., president of the Wainwright Tumor Clinic Association presided at the fortieth annual meeting held in May in Philadelphia. Speakers included **Charles R. Smart, M.D.**, Salt Lake City, Utah; **Richard B. Magee, M.D.**, Altoona, and **Antolin Raventos, M.D.**, **Robert G. Ravdin, M.D.**, **Robert W. Crichlow, M.D.**, **Walter Eaton, M.D.**, and **Werner Henle, M.D.**, all of Philadelphia. Officers elected at the business meeting were **William Tyler Douglass, Jr., M.D.**, Harrisburg, president; **Wm. C. Beck, M.D.**, Sayre, president-elect; **David D. Beiler, M.D.**, Danville, vice-president; **George R. Greenwood, M.D.**, Bethlehem, treasurer, and **Kenneth K. Meyer, M.D.**, Sayre, secretary. Directors elected for a three year term were **George P. Rosemond, M.D.**, Philadelphia; **Bruce N. Wolff, M.D.**, Gettysburg and **Mary DeWitt Pettit, M.D.**, Philadelphia.

Francis C. Jackson, M.D., professor of surgery at the University of Pittsburgh School of Medicine and chief surgeon at the VA Hospital, has been appointed director of its surgical services by the Veterans Administration. Dr. Jackson has been associated with the VA and the school of medicine for sixteen years in Pittsburgh and will be transferring to Washington, D. C. September 1, 1970.

Paul S. Friedman, M.D., Philadelphia, also was awarded the outstanding civilian service medal for "devoted and loyal service as consultant to the surgeon general of the Army and to Valley Forge General Hospital."

Captain John R. Trittschuh is Air Force Flight Surgeon of the Year. He was 1969 Flight Surgeon of the Year for the Military Airlift Command. Dr. Trittschuh, flight surgeon at Headquarters, Aerospace Cartographic and Geodetic Service, Forbes Air Force Base, Kan., was presented the Malcolm C. Grow Award during the annual scientific meeting of the Aerospace Medical Association in St. Louis. Dr. Trittschuh plans to begin his residency in ophthalmology at Wills Eye Institute, Philadelphia, this summer.

Harrisburg physician, **W. Thomas Burns, M.D.**, has been honored for his significant contribution to medical education at Harrisburg Hospital's annual "Doctor's Day" observance. Dr. Burns was the recipient of the Distinguished Teacher Award, presented by **James A. Cahill, M.D.**, representing the hospital's intern class which made the selection. Dr. Burns has been associated with Harrisburg Hospital since 1951. He is secretary of the department of obstetrics and gynecology and is active in the graduate program for interns and residents there.

A. E. Axelrod, M.D., associate dean of the University of Pittsburgh School of Medicine, spoke on "Nutrition and the Immune Process" at a meeting of the American Society for Clinical Nutrition, Inc., recently. Dr. Axelrod is recipient of a \$51,147 grant from the National Institute of Arthritis and Metabolic Diseases. Some research for this study was carried out under the auspices of the Health Research Services Foundation.

Mayer A. Green, M.D., Pittsburgh, has recently been appointed the American Medical Association representative to the International Congress of the International Association of Allergy to be held in Florence, Italy, October 12-17, 1970.

Paul A. Chervenick, M.D., of the University of Pittsburgh, has been granted the first full scholarship by the Leukemia Society to further his research on the study of cancerous white cells. He is also the associate Professor

of Medicine at the University of Pittsburgh School of Medicine.

Stephen Lockey, M.D., chief allergist at the Lancaster General Hospital, recently received the top award granted by the American College of Allergists. He has authored many scientific articles in this field.

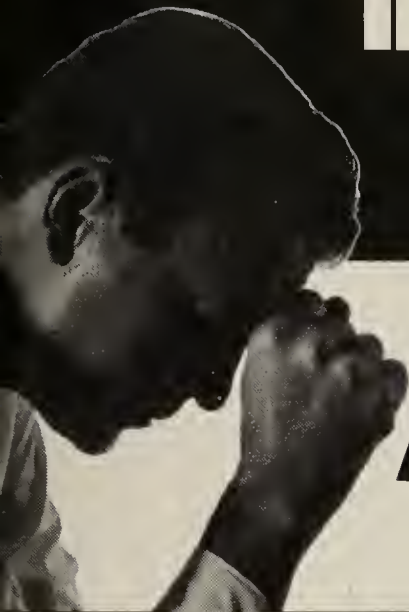
The 1970 Strittmatter Award was presented to **David A. Cooper, M.D.** He is a graduate of Jefferson Medical College with special interest in gynecology and surgery. Presently he is recognized for his study of pulmonary disease. Dr. Cooper is emeritus professor of internal medicine at the Hospital of the University of Pennsylvania.

Robert Poole, III, M.D., West Chester, spoke at the second annual symposium on medicine and religion sponsored by the Naval Hospital, Portsmouth, Va. Dr. Poole is a board member of the Department of Medicine and Religion of the American Medical Association.

Richard P. Custer, M.D., specializing in pathology, has been named senior member of the Institute for Cancer Research. Until his resignation in 1968 from the Presbyterian-University of Pennsylvania Medical Center, he served as the chief of clinical hematology and medical oncology. Presently Dr. Custer is professor of Pathology at the University of Pennsylvania.

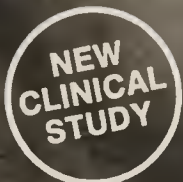
Paul C. Royce, M.D., specializing in internal medicine, was named director of medical education at Guthrie Clinic Ltd., Sayre. He succeeds **Winfield Gibbs, M.D.**, who has become resident in Radiology at the Robert Packer Hospital. Dr. Royce received his Ph.D. in physiology and was the National Science Foundation fellow and the Upjohn fellow in physiology from 1956 to 1959. He has also published extensively in the field of endocrinology. Also joining the staff of the Guthrie Clinic are **Robert W. Ridley, M.D.**, in the area of ophthalmology; **Bhagwan Wadhwani, M.D.**, in the area of pulmonary diseases; **Lawrence G. Jasper, Ph.D.**, as a clinical psychologist; and **Harry R. Wood**, in the area of audiology.

The Pittsburgh Allergy Society recently elected its 1970 officers. The president is **William C. Updegraff, M.D.** and the secretary-treasurer, **Nathaniel S. Landerman, M.D.**



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References: 1. Monteleone, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12-69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Dsol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.



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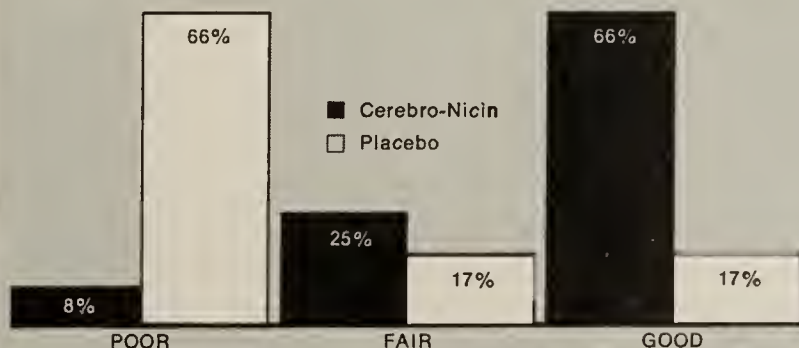
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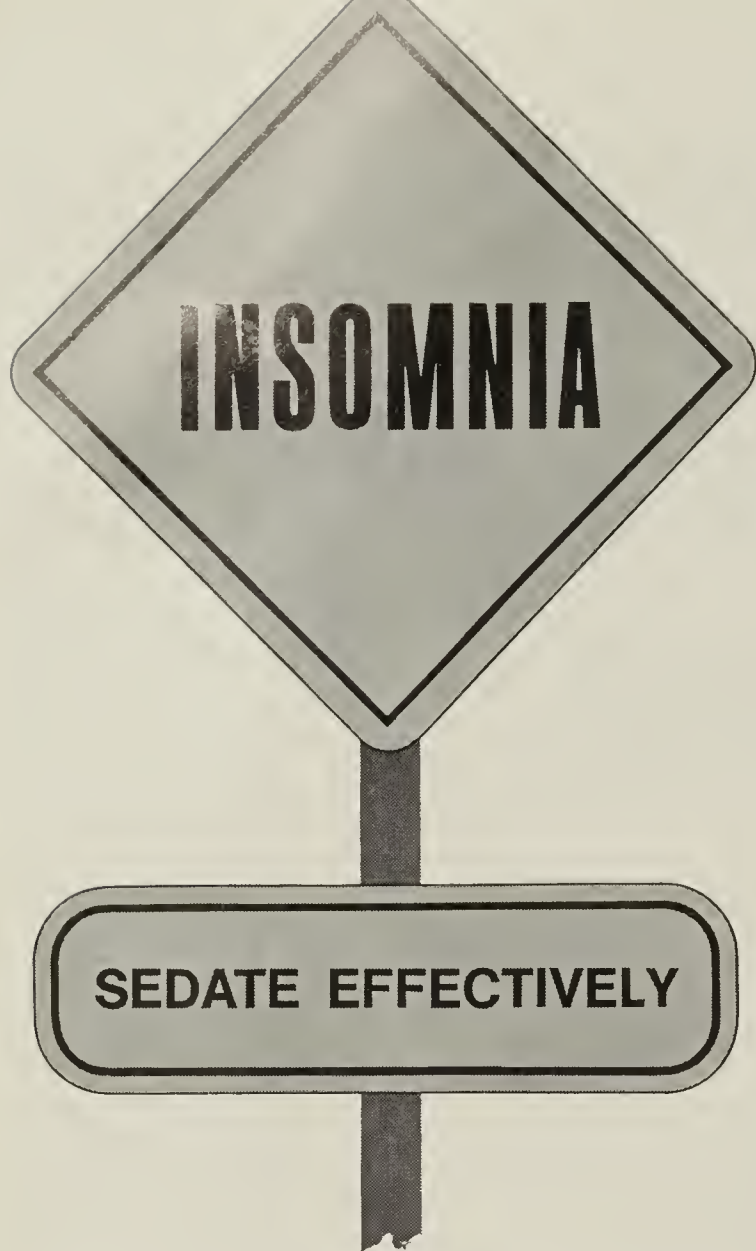
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Robert W. Ford, M.D., 9102 Babcock Blvd., Pittsburgh 15237.
Rolando G. Recio, M.D., Pittsburgh Hospital, Pittsburgh 15206.
David E. Reed, M.D., 3530 Forbes Ave., Pittsburgh 15213.
Kutub M. Saifee, M.D., 20 Cedar Blvd., Pittsburgh 15228.
Sydney A. Solway, M.D., Children's Hospital, Pittsburgh 15213.
William N. Ubinger, M.D., 525 Mt. Pleasant Rd., Pittsburgh 15214.
Ralph Gaudio, M.D., University of Pittsburgh, Pittsburgh 15213.
Harold M. Glick, M.D., Children's Hospital, Pittsburgh 15213.
William T. Green, Jr., M.D., 125 DeSoto St., Pittsburgh 15213.
Jack J. Jordon, M.D., 550 Grant St., Pittsburgh 15219.
Cuvier D. McClure, M.D., 525 Wm. Penn Pl., Pittsburgh 15222.

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Shadiya Al-Mallah, M.D., 1915 Kennedy Blvd., Aliquippa 15001.
Harvey M. Saxon, D.O., R.D. 1, Beaver Falls 15010.
Mohamed Jafarnia, M.D., 521 S. Brodhead Rd., Aliquippa 15001.

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Jugoslav M. Trsic, M.D., Harrisburg State Hosp., Harrisburg 17105.

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Irwin K. Kline, M.D., Lankenau Hospital, Philadelphia 19151.
Tilde S. Kline, M.D., Lankenau Hospital, Philadelphia 19151.
Leon M. Mielcarek, Jr., M.D., 1003 Highland Ave., Chester 19013.

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Gad G. Guttman, M.D., 1335 Tabor Rd., Philadelphia 19141.

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Alan N. Jacobs, M.D., Albert Einstein Medical Center, Philadelphia 19141.

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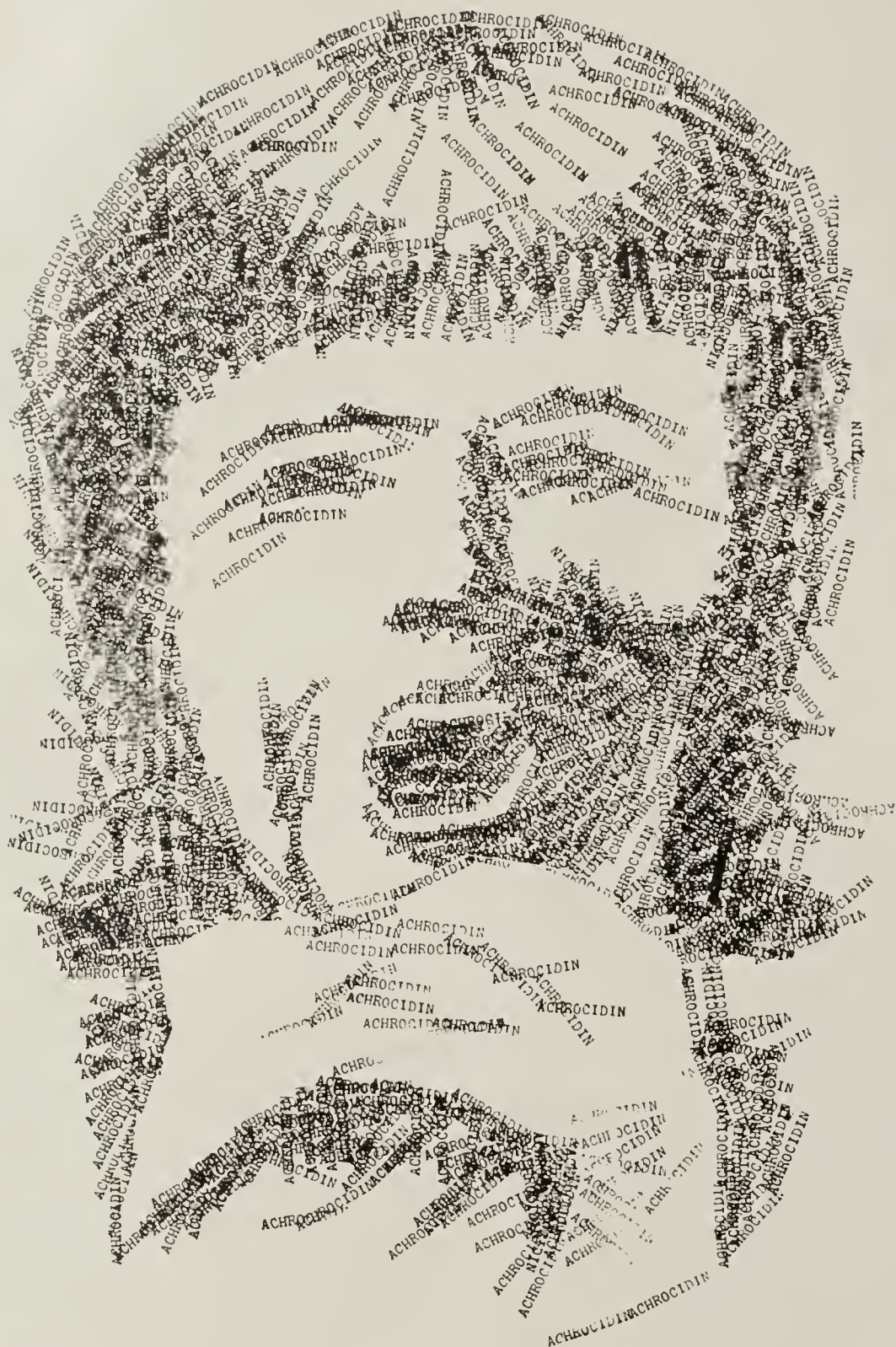
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Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons

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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculo-

popular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



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Why Group Practice?

Group practice is undergoing a major re-evaluation. Just a few years back, solo practitioners were beseeching organized medicine to declare this type of practice unethical and to withhold accreditation from the institution in which the group functioned. Nevertheless group practice has continued to grow until today about 15 per cent of the American physicians are involved in this type of practice and are providing the health needs of many millions of Americans.

Suddenly group practice is recognized by the providers of health services and organized medicine as an effective means of delivering health services to the public. Recently a group practice section has been set up in the Public Health Service to provide consultation and technical assistance to those seeking information and help concerning any aspect of the formation and operation of group medical practice.

Why the sudden change in attitude towards group practice? Why are patients and physicians being attracted towards group practice in increasing numbers?

My subsequent remarks refer to the multispecialty groups which are physician-operated and which provide integrated quality medical care to the patient while maintaining the traditional doctor-patient relationship. These groups can function within the framework of any type of prepaid health insurance.

More and more people are aware of the limitations of medical diagnosis and treatment that can be carried out in the home or in the solo practitioner's office. They no longer expect complicated diagnostic and therapeutic procedures to be available in every village. With the modern modes of transportation, patients can be transported comfortably and safely to a group practice center where their problems can be cared for by the "team of experts" approach. Patients recognize the advantages of being able to obtain complete medical care in a single institution, often in a single building, with its free access to consultation with other specialists, its unit record, and its broad variety of ancillary services. The patient is relieved of the inconvenience of traveling from consultant to consultant and the expense and annoyance of repetitious questioning and testing. The patient soon gets to know personally many of the physicians in the group and thus develops sufficient confidence in the group to accept the services of any member physician if his usual physician is not available. Also, he is assured that a qualified physician within the group is always available for urgent care.

Many physicians, especially the young physicians, recognize that their professional aspirations and their

design for living can be accomplished best by joining a medical group. The young physician is able to start with a full practice, an insured income, and the necessary diagnostic and therapeutic equipment. His working schedule can be arranged to permit time for his family, for planned continuing education, and recreation. The physician has easy access to consultants and has the assurance that when he is not available, his patients will be cared for by a member of the group.

Most of the larger groups also provide an opportunity for the physician to teach and/or participate in investigative work. In a medical group, even though located in a rural community, one can practice his specialty in a stimulating environment without fear of medical isolation.

Generally the income of a physician in group practice is less than that of the solo practitioner. However, when one considers the liberal fringe benefits offered by most groups, the disparity becomes less significant. If the monetary rewards of the practice of medicine are one's chief ambition, then he should not become associated with a medical group.

Group practice is a team effort. Each member must adhere to certain basic ground rules. If a physician is unwilling to do this, he will be unhappy in such an association. However, if a physician is interested in practicing good medicine under conditions which approach the ideal and he can work harmoniously in a team, group practice can be a rewarding experience.

Group practice in the United States has received its chief impetus from the Mayo Clinic and other large multispecialty groups through their reputation for the practice of the highest quality of medicine and surgery and through the many young men trained in these groups who, imbued with the philosophy of this method of practice, joined other groups or organized clinics of their own.

All through the years the individual groups have striven to constantly improve the quality of medical care by translating the knowledge of the researcher into its clinical application. However, largely through the efforts of the American Association of Medical Clinics, an association formed by joining together nearly 200 multi-specialty clinics, group practice has become recognized as an efficient and economical system of delivering high quality health care to the American people. Furthermore, group practice, through its more efficient use of medical facilities, equipment, and medical and allied medical manpower, has the capability of meeting the challenges of the future.

Walter I. Buchert, M.D.
Danville

Hippocrates Had Long Hair

Togetherness and concerted action were never more needed among physicians than in our present situation. It is essential that we work as a unit to protect our patients and our profession from those planners who would destroy all we have built in order to follow a utopian will o' the wisp of idealized schemes for delivering medical care.

But doctors do disagree and the extent of their variation of opinion is not negligible. One extensive area of disagreement lies in the failure of the young doctor to understand and appreciate the older man in medicine. Even more striking is the failure of the older man to understand and appreciate the young practitioner, the intern and resident population and the medical student.

This lack of rapport is particularly worthy of our attention since it is possible that we may, because of it, fail to keep building upon the edifice of medical practice constructed by former generations of physicians. The "generation gap" has no more important aspect than this.

Gaps are generally non-productive and we must face up to them. No two people have ever been found who agree in all things. Groups of people, united by common interest, could not employ their union if their agreement had to be perfect in all matters. Such groups further the ends of the human race by working in areas in which they agree and by avoiding fields of disagreement. This avoidance may be done by silent suppression of these subjects, by mutual agreement to disagree, by continuing dialogue, all aided by tolerance and good manners.

In Medicine, we must stop emphasizing disagreement, accept its presence and concentrate on areas in which we *can* agree. We are discussing the working together of practitioners of medicine but it may be well to note here that this is highly applicable to our relations with osteopathic physicians as well as with medical students, nurses and

paramedical professionals. In a mosaic of agreement and disagreement we can gain by emphasis on agreement in these and other fields.

I cite the history of mankind to support my contention that the gratifying accomplishments of the human race have been achieved by concentrating our work in spheres of agreement and by using human methods to suppress and tolerate spheres of disagreement. But history also indicates that failure to accomplish this does not generally arise from great or fundamental points of difference but from small details of varying opinion, such as the end of the egg to be selected for opening. Essentials are neglected while we go to war about accidentals.

Such is often the case with the senior physician's reaction to the new physician. The older man may be remembering a revered teacher making his Sunday rounds in formal attire and is thus disconcerted by the far less formal attitude toward toilet and dress of his youthful follower. Perhaps the senior man may have forgotten that his respected preceptor also wore a full beard and moustache and has now concluded that short cephalic and absence of facial hair are essential to medical virtue. But these and similar things have nothing to do with the young doctor's devotion to the care of patients and especially patients who find it hard to secure care. Such accidents as appearance and modes of speaking do not conceal the concern for correction of faults in Medicine and the improvement of medical care.

Let us accept the long view into the future of the youthful members of our profession along with their idealism and enthusiasm and let us keep our mind's eye on the strengthening of medicine and not on the changes in incidentals and in manners which are, in any case, inevitable.

CBL

Our Man is Honored

At the annual meeting of PaMPAC held in Harrisburg, an award was given to my boss — the medical editor of PENNSYLVANIA MEDICINE, Dr. Carl B. Lechner.

Carl has been my boss for some time now. Through this rewarding relationship, I have been privileged to be associated with a man dedicated to the advancement of the ideals and principles of our profession. Never has one been more selfless in giving of his time and effort to a reasoned and equitable approach to the solution of the problems confronting society.

In Carl Lechner there never was a credibility or a generation gap. By his wisdom, foresight, and firmness of purpose, we have all benefited and we

are fortunate to have him in a leadership role.

During the presentation I became aware for the first time that at one point in Carl's professional life he served the community of Erie as a family physician prior to his pursuit of a career in radiology. Upon reflection of this, it should really have come as no surprise. The generosity, warmth of spirit and depth of understanding he has can only come from a true physician — a healer — a comforter — a real person.

To PaMPAC I wish to say thank you for its recognition of our friend, Carl.

David A. Smith, M.D.
Associate Medical Editor

in trauma

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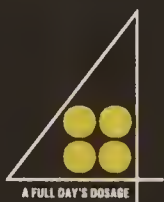
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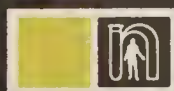
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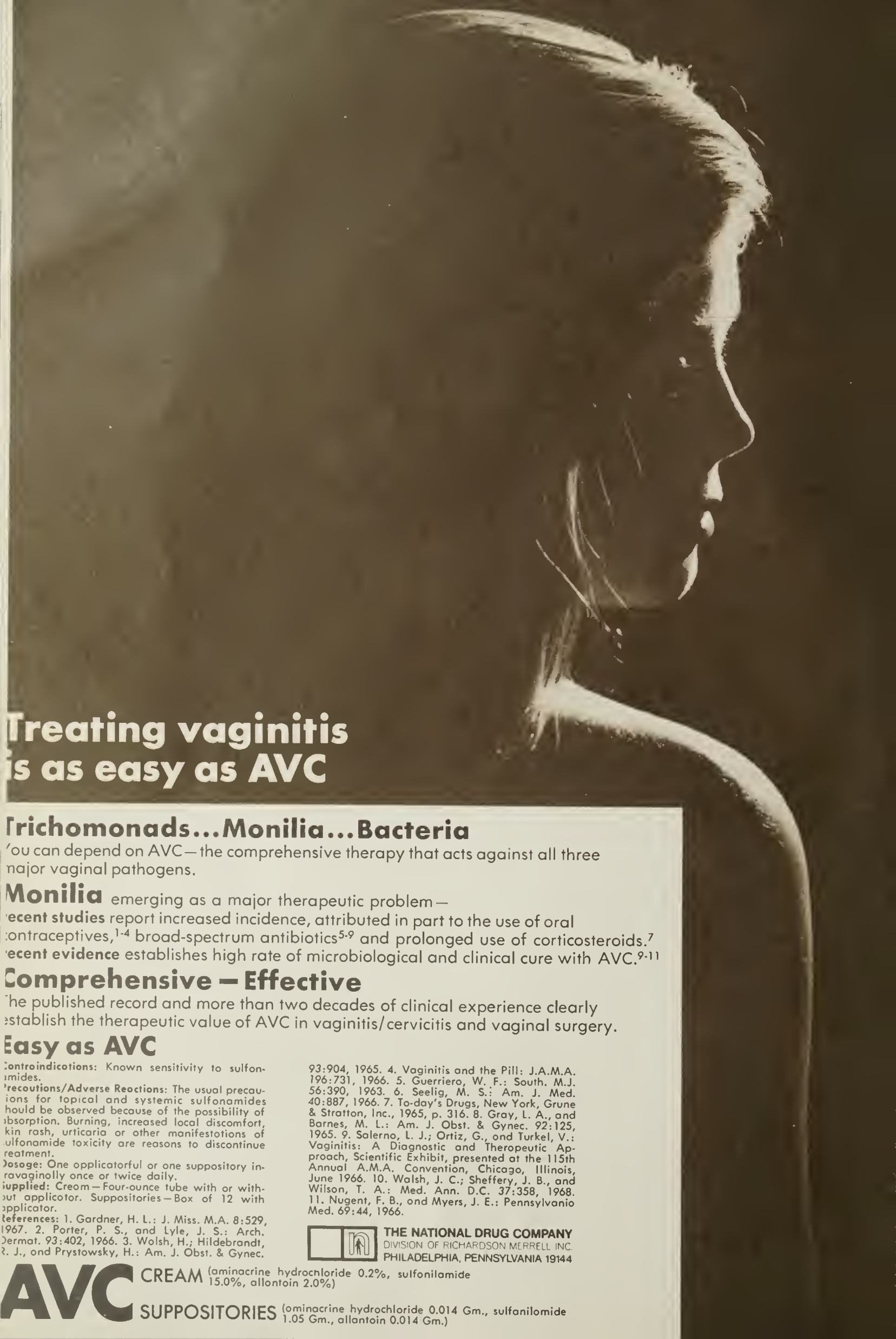
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Wolsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec.

93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.



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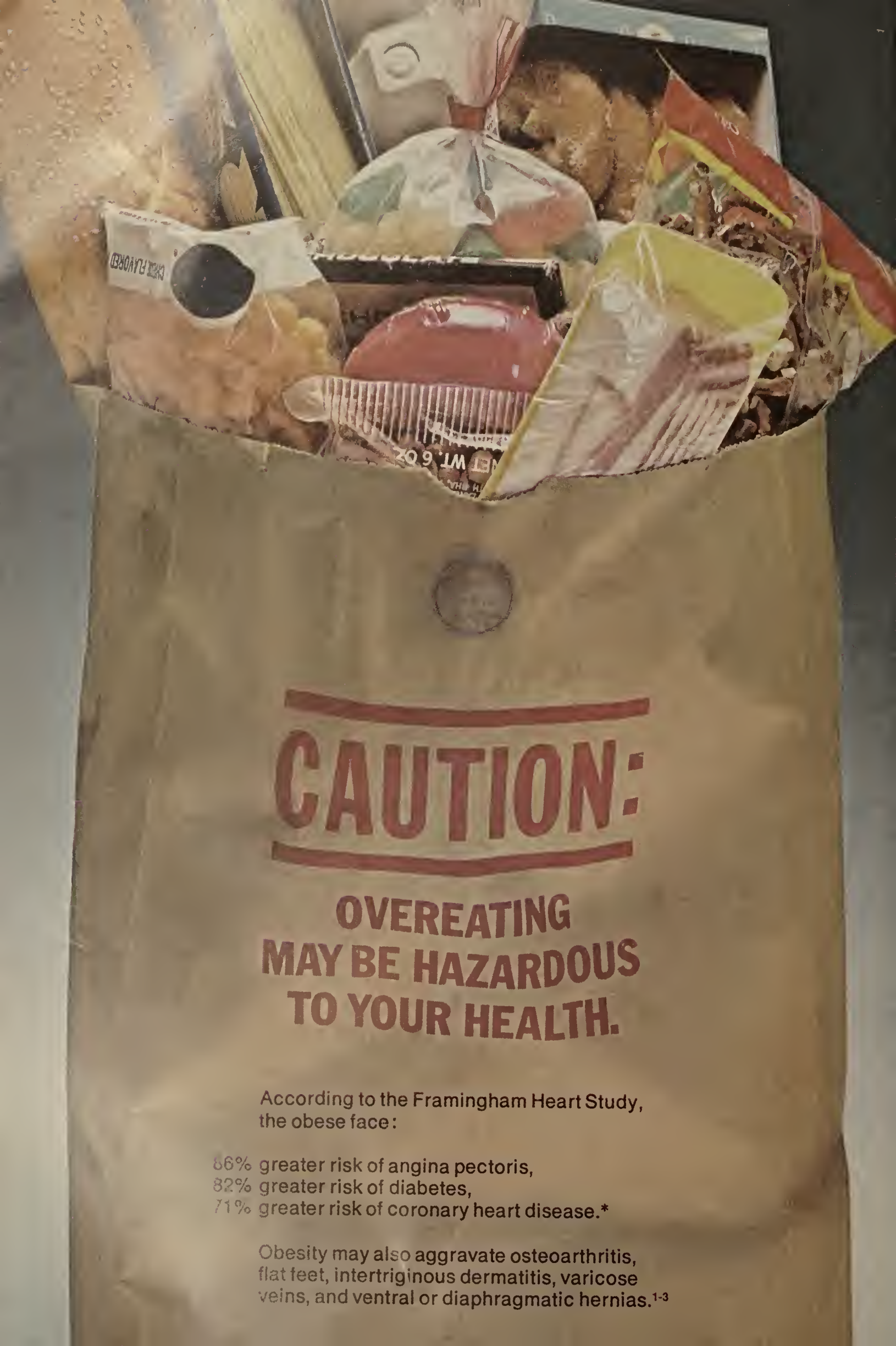
PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

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86% greater risk of angina pectoris,
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Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., et al.: *Circulation* 35:734, 1967.

2. Thomas, H.E., Jr., et al.: *Med. Times* 95:1099, 1967.

3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases

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The Geisinger Story

Hope in the Hills

WALTER I. BUCHERT, M.D.

Medical Director

The Geisinger Medical Center

Danville

Group practice is not a new, untried method of delivering medical care. Some of the larger clinic groups are more than fifty years old. This type of practice is primarily a product of the western world. The chief impetus has come from such groups as the Mayo Clinic, Cleveland Clinic, Ochsner Clinic, Henry Ford Hospital, and others, through their reputation as organizations practicing the highest quality of medicine and surgery provided by qualified specialists and also through the many young physicians trained in these clinics who, imbued with the philosophy of this method of practice, joined other groups or organized clinics of their own.

Group practice has had a very steady growth during the past half century until today groups throughout the country are serving the health needs of many millions of Americans. According to the report of the group practice survey by the American Medical Association's Department of Economics in 1966, approximately 15 per cent of the American physicians were involved in group practice on either a full-time or a part-time basis. The percentage is certainly higher today.

There are two main categories of group practice, namely, the single specialty group and the multi-specialty group. I will confine my remarks to the latter.

What is a multi-specialty group? It is a group of specialists in different disciplines working together for a common purpose, the prevention of disease and the care of the sick, with free interchange of ideas and medical knowledge and with the joint use of physical facilities, equipment, technical and allied medical personnel, and administration. Groups may vary in size from three to five physicians representing two or more specialties to several hundred or more physicians with twenty or more specialties and numerous subspecialties.

Regardless of size, all are private

organizations and provide integrated quality medical care to the patient while maintaining the traditional doctor-patient relationship.

The majority of the groups are organized as partnerships or associations. Some are incorporated under the laws of the state in which they operate and a few are chartered as tax-exempt corporations or foundations. Approximately 12 per cent of the groups operate their own hospital or are primarily responsible for the staffing of the hospital. In most, the newly appointed physician is a salaried employee for a specified period of time before he becomes eligible for election to partnership status or for membership in the association or corporation.

Because of the marked variation in organization and method of operation there is no typical multi-specialty group. Nevertheless believing that the group with which I am associated represents the type of medical care organization most likely to prevail in the future, permit me to tell you something about the Geisinger Medical Center as a basis for further discussion.

The Geisinger Medical Center is composed of the George F. Geisinger Memorial Hospital, a 380-bed general hospital, and the Foss Clinic, an eight-story outpatient facility. The center is staffed by nearly eighty full-time salaried staff physicians representing eighteen specialties and numerous subspecialties. In addition there is a house staff made up of fifteen interns and forty-two residents.

The medical center is situated in rural Central Pennsylvania in a community of 14,000 people and is 150 miles from the nearest large medical metropolitan area. Although it is a community medical facility for approximately 20,000 people, Geisinger receives 85 per cent of its patients from a 12-county area in central Pennsylvania; approximately 60 per cent of these are physician referred. Thus the medical center is the hub for specialized medical and surgical diagnosis and treatment.

Furthermore it operates a three-year diploma School of Nursing, Schools of Medical Technology, X-ray Technology, and Anesthesiology, and a course for operating room technicians. The center also offers training for its allied medical personnel such as medical secretaries, inhalation therapy assistants, nurses' aides, and doctors' assistants.

The Geisinger Medical Center, like most groups, started small with only a few physicians and the pressure from patients coming to the group has been largely responsible for its growth and development. The public is much more sophisticated today than ever before regarding its health needs and demands. The quality of medical care is being stressed both by the public and by our government. The patient knows the limitations of medical diagnosis and treatment which can be carried out in the home or in the solo practitioner's office. He no longer expects complicated diagnostic and therapeutic procedures to be available in each small community, for he has come to learn that with the modern modes of transportation he can be transported quickly and comfortably to a group practice center where his problem can be diagnosed and treated by the "team of experts" approach.

The patient is spared the inconvenience of running from specialist to specialist and the discomfort and expense of repetitious questioning and testing. After using the services of the clinic a few times, the patient gets to know personally many of the physicians in the group and thus develops enough confidence in the group to accept the services of any member physician in case of an emergency, or at times when his usual physician is not available.

In addition, the growing interest of physicians in group practice has done much to speed its progress. Many physicians, especially the young doctors, recognize that their professional aspirations and designs for living can be accomplished most fully by joining a

medical group. First, a physician is offered an opportunity to practice quality medicine under conditions which approach the ideal. The individual doctor is able to start out with a full practice, an insured income, with the availability of most of the necessary diagnostic and therapeutic equipment and with the assurance that special instruments can usually be secured on request.

The physician's working schedule can be so arranged that he can participate in an orderly personal life with time for his family, for self education, and for recreation. He has the satisfaction of knowing that when he is away his patients will be cared for by competent, interested physicians. Most clinics, especially the larger ones, provide an opportunity for the physician to teach and they encourage his participation in investigative work. In the larger hospital-based, multi-specialty groups with teaching programs, the physician enjoys a professional environment very similar to that of the university medical center.

As many of the groups are located in towns or small cities it makes compatible rural living and the practice of one's specialty without professional or social isolation. Generally the income of the physician in group practice is less than that of the solo practitioner. However when one considers the fringe benefits, such as paid vacations, reimbursed meetings and postgraduate courses, the various insurance programs, the retirement programs, and the other benefits offered by most groups, the disparity becomes less significant. The income represents the take-home pay, a guaranteed amount which comes to him at regular intervals without many of the administrative burdens that beset the solo practitioner. But, if a physician is interested primarily in the monetary rewards of medical practice, he should not become associated with a medical group.

What makes a good group? Certainly, the mere joining together of several physicians of the same or different specialties does not assure excellence. I believe there are many requirements for a good medical group but I would like to discuss briefly just a few of them.

I think the prime ingredient is the proficiency of its staff. This quality is difficult to measure but without it no group can truly succeed. It can be

achieved only by associating honest, capable, dedicated, and conscientious specialists in an environment conducive to maximum performance. The group must provide them with modern diagnostic and therapeutic equipment and assure their availability for performing those procedures for which they are most competent. The group must strive constantly to improve the quality of its patient care and its public image. Each physician should actively participate in continuing education both for himself and for others. A good educational program and quality medical care complement each other.

Secondly, a good multi-specialty group must utilize its specialists to give total medical care. Some patients complain about the too free shifting of their problems from one physician to another, thus getting the feeling that no one physician is interested in his total health. For a multi-specialty group to furnish satisfying, quality, integrated medical care for the individual patient and the family, one physician must accept and discharge the responsibility for the patient's total well being.

The unit medical record, the ease of consultation, and discussion of the patient's condition with member physicians enables the responsible physician to provide the best total medical care possible for the patient, which should be the primary goal of every group, whether large or small. Anything which compromises this ideal will lead to mediocrity and gradual deterioration of the group.

Another ingredient is "team work." This requires unity of purpose and compatibility. It means that one must accept the fact that the group is more important than any one of its members. The physician must place the welfare of the group above his personal interests and gains. There must be certain basic ground rules under which the group operates and to which each member must adhere. If this is foreign to one's nature then he will be unhappy in the group practice of medicine. This does not mean that one must be a follower or a non-thinker. Rather a free exchange of ideas and discussion when disagreements occur are important for growth and stability, provided that when the problem has been resolved, each member respecting the rights and opinions of the other works for the good of the group and its patients. Factions within a group can

only undermine its internal strength and impede its progress.

A good group must be an informed group. A network of communication must be established so that each member of the group is kept current with the day-to-day problems of operation, that he understands both sides of any disagreement, and appreciates the reasoning behind a policy decision. Those in administration must have a good rapport with all members of the group, must be good listeners, and diplomatic mediators.

Also, informal dialogue among members is important. The members of our group always have had lunch together in a private dining room. Hereby one is afforded the opportunity to converse with fellow staffmen, whom otherwise one may seldom see. I am certain that many major problems are aborted by some of these lunch table discussions. One of our physicians has aptly stated, "Just as the family who prays together, stays together, so the staff that eats together works well together."

Lastly, the group must be a diverse group. It must be able to roll with the punches and must be capable of change. The practice of medicine is undergoing profound changes. Continuously increasing demands for quality medical care by a sophisticated public and by a health-minded federal government with its constantly expanding health programs are challenging the medical profession to create a workable system that will provide comprehensive quality medical care for more and more people through the more efficient utilization of our physicians, non-medical personnel, and our diagnostic and therapeutic facilities. Multi-specialty groups have demonstrated that they are not rigid. Such a group can operate equally well in an urban or in a rural setting. It can function within the framework of any type of prepaid health insurance. It is capable of training and fully utilizing allied medical personnel and of adapting to more efficient methods of operation. Furthermore, group practice has the ability to function as a center for comprehensive (and I use this term in its broadest meaning) health care for the American people.

I truly believe that multi-specialty group practice, through the leadership of the American Association of Medical Clinics, has the flexibility and capability to meet the challenges of the future.

Group Practice- Can it Provide the Solutions?



The PMS Council on
Education and Science
Assisted in the Preparation
of this Presentation

One of the most provocative statements in a report entitled "Group Practice in Canada," published by the Canadian Medical Association in 1967, is: "Medicine is fast becoming too important a facet of our highly organized society to be considered solely in the light of the preferences of the individual doctor with respect to the degree of organization which he may or may not bring into the practice of his profession." The report hoped to convince the reader that better organization and more efficient utilization of professional staff is essential if workable and acceptable solutions are to be found to meet social and economic changes which lead to increased demands by the public for medical services. Today's practitioner of medicine must, throughout his active professional life, have time to study and attend special courses in order to comprehend the rapid advancement of medical science. The continuing and regular introduction of more complicated and highly specialized equipment, newer clinical and laboratory proce-



Multiple services are offered, and business administered efficiently.

Group Versus Solo Practice

"Group practice advantages are distinct inducements to young medical school graduates. The new physician wants to avoid a tremendous investment in an office and all its necessary appurtenances at a time when he is "broke" or in debt after years of preparation. He shies away from the long, slavish hours which he thinks solo practice demands of a general practitioner. Entering a group set-up, the recent graduate can avoid these stumbling blocks;

he can avail himself of study and research opportunities, and can learn from his more experienced associates; his wife will probably take much more kindly to his being part of a group than she would to his engaging in the much more confining, demanding role of the solo practitioner." — Edward J. Kowalewski, M.D., President, American Academy of General Practice, PENNSYLVANIA MEDICINE, February, 1966.

dures and more advanced technical skills places a heavy professional and financial responsibility on the doctor of medicine. He should not depend on hospitals or governments, under all circumstances, to provide him with the diagnostic and treatment facilities required for patients who are able to come to his office.

Doctors in private group practice have the same close relationship with their patients as individual practitioners, and the patients know that all of the professional persons in the group are at their disposal for diagnosis, treatment and rehabilitation.

The purpose of group practice is to develop high quality medical care and to provide medical coverage for patients whenever it is needed. The Canadian report continues that group practice fulfills this purpose when the following criteria are met:

1. The knowledge and skills of many doctors are made readily available to the patients of the group.
2. The training and skills of the various allied health professions are fully utilized.
3. Modern equipment is efficiently employed.
4. The clinical record of each patient, including x-ray and laboratory reports, is maintained properly and always accessible.
5. Scientific meetings and the publication of medical articles, including case reports, are part of the group educational program.
6. Clinical research is encouraged

and basic research is supported when circumstances permit.

7. The net income of the group is distributed according to a formula which, in addition to the volume of professional work, recognizes special professional merit and individual contributions to the development, organization and administration of group practice.

In light of the political, social and economic changes facing medicine and the sustaining effort by government to encourage group practice, PENNSYLVANIA MEDICINE visited two multispecialty groups in Western Pennsylvania to get a first hand accounting of the key factors that make group practice a better way to deliver health care services. In any care delivery system, there are problem areas, philosophy of practice, and compensation factors that affect the physician participants. These were pursued in depth. The first interview is with T. V. Murray, M.D., a general surgeon in the Sharon Medical Clinic, Ltd., 912 E. State Street, Sharon. This group practice is composed of nine physicians, two in general medicine, one in internal medicine, one ophthalmologist, two in surgery, two in radiology, and one in obstetrics and gynecology. Our second interview was with R. W. Andrews, M.D., an obstetrician with the Greenville Medical Center at 90 Shenango St., Greenville. This multispecialty group is composed of thirteen physicians, 10 of whom are board certified. It was founded in

1946, services an area of fifty miles with a population of 125,000, and has been a member of the American Association of Medical Clinics for eighteen years. The Greenville clinic has three internists, one of whom has a subspecialty of allergy, two pediatricians, three specialists in obstetrics and gynecology, one surgeon, two urologists, one anesthesiologist and one radiology consultant. This clinic also has a business manager.

Sharon M.D. Thinks Aloud

If I were to walk out of here tomorrow and just took the net asset or the net cost value, I would have somewhere in the neighborhood of \$60,000 which is an equity that has been built up. I've never seen these dollars and yet can't ignore them. They're there.

One of the hardest things in group practice is sublimation of your own ego, trying to get your patients to see any one of you.

The other doctors now accept us much better than they did when we started. Everybody was antagonistic. Some would send patients out of town rather than send them to us, but I think that has largely disappeared. We worked it out.

Cooperation

My office nurse weeds my patients out. A patient that I had taken on surgically showed up yesterday and I saw him sitting there but I didn't see him. My nurse said he was in because he had a sore throat and bad cough,



Patient preference regarding way to pay can be accommodated.

and she just sent him up to see the general practitioner without bothering me. This is fine; this is where cooperation pays off. By the same token, when the GP gets something, he will send it here. Sometimes it's an imposition when you have twenty patients to see and another member of the group has sent two or three patients; at the same time, I'm going to impose on them the same way. You have to be a certain type of person to accept this. Some people are just too independent, particularly, I think, after they've been in practice for years. As far as time in the office is concerned, we run a theoretical vacation schedule in which we allow two weeks vacation. We get two weeks or ten leaves a year to begin with and that will increase to three weeks. I don't take many vacations. I take long weekends, like from Wednesday to Wednesday. As long as my work is covered, there is no argument from my associates. That's an asset of group practice.

Income

Despite all the articles in *Medical Economics*, you can make more money in private practice than in group practice. One of the troubles of group practice is that if I go out and order a piece of equipment, it doesn't cost me anything out of my pocket, it comes out of a separate checking account. As a consequence I am not really aware of how much difference this makes in my income and everybody tends to overspend a little bit. You have to have controls on what you are spending.

Our income distribution is based on approximately a 50 per cent equal distribution. We have a drawing account and a monthly salary, and a monthly bonus. The rest is distributed percentage-wise according to the net profits. Every three months we distribute the profits. If there is \$10,000 profit and I get 10 per cent of the business, I get \$1,000.

If I contribute 10 per cent of the work as recorded on our books by the end of a period of time and there was \$10,000 to be divided, I would end up with a bonus of \$1,000 at the end of that three-month period. We trust the system that you're not going to charge somebody \$1,000 when you know they are not going to pay anything. You don't expect to get paid so you don't put the charge in.

Manpower

We try to increase our efficiency and do the things that we're really trained to do. A lot of doctors do their own accounting at night and we don't. We're strictly practicing medicine and the other necessities which have to be done by somebody we are paying to have done.

Prepaid Group

I think you need a much larger group for prepaid insurance to work. You almost have to have every doctor in town active to handle prepaid situations. We are without a urologist. What happens when a patient has a urology problem? You either have to eliminate certain things or we have to pay a

urologist a standard fee out of our pocket, and I don't think we could continue to do it. We were very interested in this idea and we met with some of the union leaders. Our thinking was so much per family per month. The union men thought this was wonderful and they wanted to take us up on it right away. However, they wanted to pay less than for what we could afford to do it.

Problems

We've had a few problems with our group, there has been a lot of turnover. I've been here twenty-five years the first of August and some people fit into this concept and some do not. Of the original group, there are only two of us still here.

These things are going to happen. You find out that there is no way that you can judge what an individual is going to do. We bring them in on a two-year probation period. Even two years doesn't give enough time for a man to make up his mind as far as his personal and professional life is concerned. Our biggest difficulty is getting physicians. We just don't. I suspect we don't offer them enough money.

Quality Care

I think that we have improved medical care in our community. Certainly there is no question that two surgeons working together talk over their problems. We have nothing to hide. We say what we think. And this has been a great help. You're kind of foolish in this day and age if you don't have your care checked over by an internist. You give them the best that you have.

We pioneered the complete physical examination in this town and now many of the doctors are doing it. I don't mean to infer that some of them wouldn't have done it on their own but some of the patients came in for a complete physical and ended up with a \$75 or \$100 bill and this was twenty years ago, you could hear them screaming all over the town. And we had quite a reputation for high charges. Our charges were not high, they were average charges. We charged for our cardiograms what they charge in the hospital. We charged for x-rays what

Better Health Care

"I believe that the American people are now asking the question loud and clear. They want to know when and how they shall receive better health care at prices they can afford to pay. We who believe in group practice have an answer. It is not the whole answer, nor the only answer, but it represents a valid and important approach." — William H. Stewart, M.D., Former Surgeon General, Public Health Service, U. S. Department of Health, Education, and Welfare.



Efficiency does not deter personal attention.

they charge in the hospital. And our laboratory tests are on the same basis.

Greenville Doctor Speaks

The basic philosophy of group practice has to do with a man's individual personal position as to how he wants to practice medicine today and how he is planning the rest of his career. As a practical matter, it takes a lot of doing to get people who are used to working in an individual manner to work together. The physician is very individualistic because everything he does involves a judgment factor relating to a patient. Many use this as a reason to close their minds to the fact that there are other ways of practicing medicine.

Please do not think of group practice as the solution to our problems of today. In the first place, we have numerous problems, let's face it, and group practice alone is not going to answer all of them. The organization of a group practice is mainly dependent upon the eagerness of a man to provide better medicine. Now that may sound corny but I'm sure if I were to open a speech anywhere with that sort of

statement, they'd say, well this boy is blowing his own horn. Well, it's a little like marriage. There are a few things you're going to learn after twenty-four years.

Pride—Growth of Medicine

You can get over it with it. Every day I walk into this unit, I feel proud of being a part of the outfit. I feel that I am doing more than just practicing medicine, I'm engaging in the growth of medicine. Now's that part of the philosophy that you must have if the group is going to go.

Change From Solo Practice

Group practice is not a way of life in the east. Most of the physicians in our part of the country are still unwilling to take a chance and are much happier as solo practitioners. To become a member of a group practice is not an easy change from solo practice. It can be a very enlightening experience; there are many times that you have to do a lot of compromising. The biggest trouble today about the group practice situation is that there are enough men who would like to do it but they're

scared. They just do not want to give up some of their own personalities and incomes, and make compromises.

The physician is ready for group practice right out of internship. This is the best time to begin. As far as I am concerned, you don't take a man at age forty or fifty because he's been disillusioned somewhere else, or is retiring after 20 years in the service. If you're going to raise them, raise them right from the beginning.

Wants of Young M.D.

They expect a salary which we find pretty darn difficult to guarantee them to start. They're a beginning business. We're going to have to put them on trial. Are they capable of the work? Have they the personality to sell themselves? The money is here and what does he do? He sits down in one of those offices and he doesn't buy anything. Not even his own stethoscope. He even gets his white coats supplied. They immediately get an idea that they are going to be covered and that they just do not have to work at building a practice. Well, that hasn't changed one

bit. You still have to work at building this practice.

Other M.D.'s In Town

There is no need for them to be enemies, but keep in mind they are competitive forces. You work on committees together and you get along. But unless you are going to offer some of the super specialties, neurology, surgery, something of this sort, don't expect referral work from the men within the community. I'd say here that things are fairly equal and the power of the outside about equal to the power inside the clinic as far as the staff on the hospital and this kind of thing, so both sides know that if they want to get anything done at all, they'll have to work together.

Costs Less to Run A Group

Let's not kid ourselves on the fact that it costs less to run a group practice because we run a better organization than a solo man does, except for the exceptional man. We have over thirty paramedical personnel, believe that we are right on our toes, including a full-time manager. Certainly he costs more than some little gal that is going to sit in the corner of the office and run your business for you, but he's there doing a job. Now next month he'll be going away to get ideas on computerization. We're thinking ahead.

Efficiency

Here's my pitch for group practice. Let's say one solo practitioner has two girls working for him. They make appointments, they keep the books, they type the letters, they put the people in, they take the cash, they write the checks for him. Now, if they've worked for him long enough, they'll do a fairly decent job. We have one medical secretary doing an excellent job for thirteen men. The same thing goes on the business side of it. If a girl is assigned to work on credit and collections, she really gets things done. If you have lay people specializing on a job they become more efficient.

Manpower

There's a lot of dreaming about group practice these days and the government is making a big play that this is the answer for manpower difficulties. I don't think this is going to answer all of it. We have a nurse's aide who handles patients for three of us in

obstetrics and gynecology. Think of it, one girl. Now we could afford to have more, but this one is doing the job. You arrange it so a doctor uses his skill, which is to talk with the patient, and everything else that is practical is given to paramedical personnel. You should be increasing the output of physicians.

Time Off and Coverage

Time off—you've got to be careful. It's so easy to let somebody else do it. We consider we're covered. I think this fellow's on. And the next thing you know, he just may not be on. We have a schedule and we adhere to it carefully. When I go home, I can plant trees, I can feel quite free because of it. I have every third weekend that I don't have to be anywhere near the place.

Fringe Benefits

There are certain fringe benefits. I think that the pride of producing and being a member of a group which has done what this has done for this community amounts to something. There's an interesting facet about group practice. You invest in your own business. Now you just don't buy a thirty-foot boat or a \$25,000 airplane. You invest in your own business and it's a matter of enforced savings. We are all partners in this group after two years and we invest in our business. Now the monies that I and the other men have invested in our corporation, which has to do with the land and buildings, is returning us as nice a return as anything that I have. And when the day comes, one of the real solid portions of my estate is what I have put into this business. What does a solo practitioner have when he tries to sell a practice these days? Nothing.

Continuing Education

This is a matter of personal interest. He can have a month and a half every year. Many of the groups are more liberal than that. Some have their own sabbatical setup. The reason we can't is that we're not deep enough in our departments. But our men have ample opportunity. We're close enough to the city that practically everyone of our men belongs to the specialty groups.

Patient Attitude

There isn't any old-fashioned patient to my way of thinking. The education of the patient today is out



*Comprehensive
Medical Records
are kept
in Libraries*



*"Group practice
was once
almost a
dirty word...
we weathered
that concept."*

of our hands. People quote the newspaper, they're well educated. I don't have to talk about their cholesterol. They ask me, well doctor, are you going to do a cholesterol? Now is that an old-fashioned patient? Remember, everybody has old-fashioned problems but they are very much interested in having the latest information on them.

Community Attitude

I think the community has never completely understood the group. In a small community, it takes several years for them to become accustomed to the group because it scares them. You take a patient out of the surrounding of an individual physician's office with one or two girls and suddenly confront him with an admission sign, stop here, etc., and the people rebel; they're scared. I think that many of the patients in this community who don't come to us still go to the other man because they are attempting to hang on to what they believe is a more personal method of providing medicine, "their doctor." The physician outside is no more their personal doctor than we are.

Improved Community and Hospital Care

Group practice was once almost a dirty word. But we weathered that concept and we've grown in stature. It has meant to this community the attraction of many specialties. Before World War II, we had a hospital of fifty-two beds, now it's 165 in a town of less than 10,000.

The next move will be thirty-five additional beds for progressive care so you know that there is some association between instituting a group practice in a community and what happens to the hospital. For example, we had a part-time radiologist who came to see us in the hospital twice a week. We had no pathologist. We sent everything out. We sponsored the first radiologist and brought him to town as a partner. We sponsored the first pathologist and brought him here as a partner. So it was with anesthesia. Of course, in due time, the hospital realized the income from radiology and pathology. We showed them the way. Now our radiologist is part time in our clinic and the pathologist is full time at the hospital. The anesthesiologist is a member of our group. The group has

definitely enhanced the practice of medicine in this small community, there is no question about that in my mind.

Ghetto Care

I think there are two ways to provide care for the ghetto. First a very sound social welfare program is needed, with a lay person to go out and find those in need medically. Secondly, a practice which is under the sponsorship of either a medical school or a large hospital and which is manned by several physicians is needed to give the care.

Prepayment

Prepayment is certain to come. There has been trouble earlier in this sort of thing. Plans were initiated by groups such as miners. But you refer to a group practice which is started by physicians themselves, with the modality for prepayment, say a steel company. Yes, it's a possibility. It has to be comprehensive. That's what the people are yelling for.

Establishing A Group

To organize and establish a successful medical group is a creative act demanding careful planning, realistic foresight, and large measure of effort. The Liaison Committee of the American Association of Medical Clinics, the American Medical Association, and the Medical Group Management Association, has prepared a booklet of limited factual information about the elementary problems confronting physicians who are contemplating establishing a medical group or who are thinking of joining an established group. This booklet is available through the Group Practice Information Center maintained by the Special Committee on General Practice of the State Society. The Group Practice Information Center also can provide names and locations of various multispecialty or single specialty groups in Pennsylvania. Experience has indicated that the best way to understand the many facets of group practice by a physician interested in starting or becoming a member of a group is to visit a group based on a similar philosophy. If you are interested in knowing more about group practice, contact the Group Practice Information Center, Pennsylvania Medical Society, Lemoyne 17043.

Hahnemann Interprets EKG In One Minute with Computer

An electrocardiogram can be interpreted in about one minute at Hahnemann Medical College and Hospital, Philadelphia. This is the first computerized ECG system in the city and one of the few in the country.

"Speed is only one of the advantages gained by computerizing ECGs," according to Leonard Dreifus, M.D., clinical associate professor of medicine, acting director of the Hahnemann division of cardiology. "Because the computer is programmed with constant criteria, all ECGs will be interpreted consistently. Human variation will be virtually eliminated. Computerization will provide more accurate and more complete information than was previously available; and the cost per ECG will be reduced.

"Comparison of ECGs over any given period of time will be another advantage. There has never been a practical, workable means of reviewing 100, 1,000 or 10,000 ECGs. Now, because the computer will store the information, it can be presented and analyzed on demand."

Financial support for the project has come from the National Institutes of Health, Blue Cross of Philadelphia, and Hahnemann. It is another step toward improved patient care while instituting a cost effectiveness program.

Thomas F. Manley, president, Blue Cross of Greater Philadelphia, said "Computerization of ECG analyses promises to prove a valuable effort in the reduction of costs for at least one element of hospital care. Many more innovations of this caliber are needed today.

"The new system has the potential for lowering the average cost of electrocardiograms from \$14.00 to \$7.00, and could even reduce it to as low as \$3.75 when the Hahnemann center is used by other hospitals throughout the city, via wire, for remote analysis."

Hahnemann's program is an adaptation of the program used at the Mayo

Clinic. However, it is uniquely geared to the needs of a large teaching hospital, and is oriented for regional cooperation among many hospitals in the near future. It also reflects Hahnemann's broad experience in cardiovascular disease over the past two decades, under the leadership of William Likoff, M.D., clinical professor of medicine.

The system uses the Bell Telephone Data Phone, dialing cards, an IBM 1800 computer and Marquette Electronics Data Acquisition machine. In the near future, a microfilm component will be added, so that the final ECG will not only be processed completely automatically, but will also be stored on an aperture card (a computer card with the microfilm inserted).

The cart used by the ECG technician is not much larger than the standard ECG cart. However, it contains the telephone, the ECG machine and vector cardiograph; and it still provides a directly written ECG.

First, the technician attaches the leads to the patient. Then, using the dialing card, the computer is called. The computer verifies the patient identification and signals when it is ready to receive the ECG. When the computer has recorded the information, it signals the technician that it has received the complete "message."

If an ECG is needed in an emergency, the technician instructs the computer from the telephone console on the cart. The computer then moves that particular ECG ahead of all others in the machine for instant interpretation. The computer prints out the ECG chart and the interpretation of the data in about one minute. It takes about five minutes to prepare the patient, communicate with the computer and record the ECG.

With the new system, Hahnemann has programmed not only the twelve leads of a traditional ECG, but three additional orthogonal leads and vector loops. These latter leads, which show

instantaneous electrical events of the heart, have not been routinely handled previously because it was impractical and too time-consuming to interpret their data. This information was previously only taken on selected patients.

The ECG taken at the bedside is placed on the patient's chart on the floor so that the attending physician has access to it immediately. Within three hours it is replaced by the computer print-out of the ECG and the computer interpretation. Previously, when an ECG was made, it was returned to the "heart station" for interpretation and then was sent back to the floor, which took nearly twenty-four hours.

Hahnemann takes and interprets about 100 ECGs daily. The computer has the capacity to handle 300 ECGs per day. It has taken five or six doctor-hours a day to read and interpret Hahnemann's ECGs. It took another hour to check the interpretations. Now it will take one doctor about one half-hour per day to check 100 computer ECGs and interpretations.

It took Hahnemann 18 months to engineer the system and make it functional.

"It would probably take less than a year to prepare another hospital to go on-line with us," Perry Scheinok, Ph.D., research professor of physiology and biophysics, and director of the computer center, said. "But we are looking forward to developing this method as a service to community hospitals and for hospitals which have teaching affiliations with Hahnemann, and area nursing homes that have no ECG services. As the total volume of ECGs increases, the cost per ECG will be reduced.

"We will be constantly revising and refining our criteria in concert with the newest developments in cardiology. This would mean that community hospitals coming on-line with us would have the benefits of the most modern diagnostic and therapeutic information available."

Treatment with Intranasal Dexamethasone Sodium Phosphate

Aaron E. Fishman, M.D.

and

Samuel E. Rynes, M.D.

Philadelphia

During the past decade, numerous investigators have published reports of uncontrolled studies on the use of intranasal steroids in treating nasal allergic conditions. Their results have confirmed the therapeutic utility of topical steroids in relieving the symptoms of allergic rhinitis, nasal polyps and pollen hay fever.¹⁻¹⁰

Over the past four years, controlled studies with intranasal dexamethasone sodium phosphate have corroborated these results. Few side effects were reported and there was no evidence of seriously impaired adrenocortical function from the dosage necessary to suppress symptoms.

Evidence of a high response rate to intranasal dexamethasone therapy was found by several investigators. Norman et al¹¹ concluded that intranasal dexamethasone used as an aerosol was much more effective than the equivalent weight of dexamethasone given orally. They found the intranasal method effective in suppressing hay fever symptoms in about 75 per cent of 102 patients. Aaron and Muttitt found that 25 out of 26 patients with uncontrolled perennial allergic rhinitis had good to excellent symptomatic relief within one week with intranasal dexamethasone phosphate inhalations. Good to excellent results were continued on a reduced maintenance dosage.¹² Chervinsky treated 30 allergic rhinitis patients with intranasal dexamethasone phosphate using maximum dosages of 0.5 mg. daily, and found that symptoms

were effectively controlled in 90 per cent of the cases¹³. Norman and Winkenwerder treated 40 patients in a double-blind study with 1 mg. intranasal dexamethasone phosphate daily and found hay fever symptoms were relieved in 75 per cent of cases. No steroid side effects were observed.¹⁴

Results of another double-blind study of dexamethasone nasal aerosol compared with placebo in the treatment of nasal polyposis yielded evidence that dexamethasone nasal aerosol is moderately effective in controlling allergic rhinitis complicated by polyps.¹⁵

Other investigators have described the mechanism by which steroids protect the cell. Humphrey et al¹⁶ hypothesized that the inflammatory response of the cell is reduced by glucocorticoids by a mechanism which raises the threshold at which a damaging agent causes increased permeability of the small vessels. This preservation of cellular integrity, in turn, reduces the exudation of fluid and phagocytic cells.

Dougherty¹⁷ described the stabilization of the lysosomal membrane against allergic insult and noted that this phenomenon was demonstrated by advanced cinemicrographic techniques.

Connell¹⁸ showed that the response of the nasal airway to pollen probably is local and not systemic and that psychologic factors do not cause hay fever symptoms. Once the disease exists, however, emotional stress may worsen the symptoms. He noted also that nasal hyperactivity in response to

one antigen increases susceptibility to other antigens.

There is some systemic absorption of steroids used intranasally. Aaron and Muttitt¹⁹ found that there was some systemic absorption of dexamethasone phosphate spray, evidenced by increased urinary excretion of the total 17-ketosteroids, the 17-ketogenic steroids and the 17-ketosteroids. When the spray was used only once daily, the systemic absorption was much less. Adrenal function was not seriously impaired, however, even with more intensive use.

The purpose of the present study was to determine the effectiveness of dexamethasone phosphate by intranasal spray in the treatment of ragweed hay fever for the 1967 fall season.

Materials and Methods

One hundred patients with symptoms of ragweed hay fever, which was corroborated by positive skin tests (for the offending allergens), were selected for a double-blind crossover study. The patients were of both sexes and ranged in age from 13 to 60 years.

Before treatment was started, each patient had a physical examination, with particular attention to the following symptoms and signs: sneezing, stuffy nose, running nose, red itching eyes, post nasal drip, anosmia, conjunctivitis, nasal edema, amount of nasal secretion or obstruction, and the color of the mucus membranes.

All patients were given three identical-appearing aerosols, one of which

Table 1

Results For Period I

Parameter	Time of Visit	DEXAMETHASONE SODIUM PHOSPHATE			PLACEBO		M Ch
		No. of Patients	Mean Score	Mean Change	No. of Patients	Mean Score	
Symptom:							
Sneezing	Initial	37	2.2		43	2.2	
	1st week		1.6	- .6***		2.1	-
	2nd week		1.4	- .8***		2.4	+
Stuffy nose	Initial	37	2.3		35	2.4	
	1st week		1.5	- .8***		2.1	-
	2nd week		1.3	-1.0***		2.5	+
Running nose	Initial	31	2.3		35	2.3	
	1st week		1.4	- .9***		2.0	-
	2nd week		1.3	-1.0***		2.4	+
Red itching eyes	Initial	19	2.3		25	2.2	
	1st week		1.6	- .7**		2.2	
	2nd week		1.6	- .7**		2.2	
Post nasal drip	Initial	8	2.4		14	2.3	
	1st week		1.9	- .5		2.2	-
	2nd week		2.0	- .4		2.4	+
Anosmia	Initial	3	2.3		5	2.4	
	1st week		2.0	- .3		2.2	-
	2nd week		1.6	- .7		2.8	+
Sign:							
Nasal discharge	Initial	10	2.0		7	2.1	
	1st week		1.6	- .4		1.7	-
	2nd week		1.2	- .8**		2.1	
Nasal obstruction	Initial	11	2.1		6	2.2	
	1st week		1.6	- .5		1.9	-
	2nd week		1.1	-1.0*		2.0	-
Nasal edema	Initial	12	2.1		6	2.0	
	1st week		1.6	- .5		1.8	-
	2nd week		1.4	- .7*		2.0	
Conjunctivitis	Initial	4	2.5		2	2.5	
	1st week		1.2	-1.3		1.5	-1.
	2nd week		1.0	-1.5		2.0	-
Mucous membrane Color +	Initial	7	2.3		7	2.6	
	1st week		1.9	- .4*		2.7	+
	2nd week		1.9	- .4*		2.7	+

Mucous membrane color was scaled as follows:

1 = normal, 2 = slightly pink, 3 = very slightly pink, 4 = pale.

* Statistically significantly greater decrease than placebo group (P < 0.05)

* Statistically significantly greater decrease than placebo group (P < 0.01)

* Statistically significantly greater decrease than placebo group (P < 0.001).

Table 2
Periods I and II - All Data - Cross-Over Design

Parameter	Time of Visit	No. of Patients	DEXAMETHASONE SODIUM PHOSPHATE	PLACEBO
			Mean Score	Mean Score
Symptom:				
Sneezing	1st week	86	1.6***	2.0
	2nd week	86	1.4***	2.2
Stuffy nose	1st week	86	1.7**	1.9
	2nd week	86	1.3***	2.1
Running nose	1st week	86	1.5***	1.9
	2nd week	86	1.3***	2.2
Red itching eyes	1st week	86	1.5**	1.7
	2nd week	86	1.3***	1.8
Post nasal drip	1st week	79	1.3	1.5
	2nd week	79	1.2***	1.6
Anosmia	1st week	79	1.2	1.2
	2nd week	79	1.1**	1.3
Signs:				
Nasal discharge	2nd week	86	1.3***	1.9
Nasal obstruction	2nd week	86	1.5***	2.2
Nasal edema	2nd week	86	1.7***	2.3
Conjunctivitis	2nd week	86	1.2***	1.6
Mucous membrane color	2nd week	83	1.9**	2.6

Scale: 1 = none, 2 = slight, 3 = moderate, 4 = severe

** Statistically significantly less severe than placebo (P < 0.01)
*** Statistically significantly less severe than placebo (P < 0.001)

Table 3
Summary of Patient's Feelings at the End of Each Period in Comparison with Last Year

	Group I (43 Patients)		Group II (43 Patients)	
	Period I DEXAMETHASONE SODIUM PHOSPHATE	Period III PLACEBO	Period I PLACEBO	Period III DEXAMETHASONE SODIUM PHOSPHATE
0 = Much Improved	22	6	1	18
1 = Improved	18	11	4	23
2 = Same	3	20	33	1
3 = Worse	0	6	5	1
4 = Much Worse	0	0	0	0

Overall Means DEXAMETHASONE SODIUM PHOSPHATE = 1.1***
PLACEBO = 2.7

*** Statistically significantly greater relative improvement than with placebo (P < 0.001)

contained dexamethasone sodium phosphate. The other two aerosols contained placebo. Each dexamethasone aerosol cartridge contained dexamethasone sodium phosphate, equivalent to 18 mg. dexamethasone phosphate or 15 mg. dexamethasone. The contents were dispensed in metered sprays, each spray containing dexamethasone sodium phosphate equivalent to approximately 0.1 mg. dexamethasone phosphate or 0.084 mg. dexamethasone.*

The patients were given the first aerosols when definite hay fever symptoms appeared, and were instructed to use two sprays in each nostril three times daily for two weeks. At the end of this period, the patients received the second aerosol, which contained placebo, with instructions to use it for two days. If the first aerosol contained dexamethasone sodium phosphate, the placebo washed out any residual steroid. Then they were given the third aerosol to be used at the same dosage as the first and second for two weeks. For convenience in describing the response to therapy, the schedule of treatment was divided into Period I (2 weeks): dexamethasone sodium phosphate or placebo, Period II (2 days): placebo alone, and Period III (2 weeks): dexamethasone sodium phosphate or placebo. Chlorpheniramine maleate* tablets 4 mg. were supplied as needed as adjunctive therapy to control symptoms.

Patients were observed for signs and symptoms at the end of each week of therapy during Periods I and III. Only a few patients were seen at the end of the two-day intermediate placebo period. After 30 days of therapy, the patients returned to the office, and the empty aerosols and clinical information were returned to the manufacturer, who had the code as to which aerosols contained placebo and which had dexamethasone phosphate. The results were then statistically analyzed.

Results

Eighty-six of the 100 patients completed the study. The other 14 were not included in the statistical analysis because 7 of them did not follow directions, 3 stopped the medication because of apprehensiveness, 3 others complained of nasal irritation, and 1 had headaches.

Table 4
Periods I and III - Patients' Treatment Preference

Parameter	Group I (43 Patients)		Group II (43 Patients)	
	Period I: DEXAMETHASONE SODIUM PHOSPHATE	Period III: Placebo	Period I: Placebo Period III: DEXAMETHASONE SODIUM PHOSPHATE	Combined
DEXAMETHASONE SODIUM PHOSPHATE much better than placebo = +3	7		18	25
DEXAMETHASONE SODIUM PHOSPHATE better than placebo = +1	25		19	44
DEXAMETHASONE SODIUM PHOSPHATE same as placebo = 0	7		3	10
DEXAMETHASONE SODIUM PHOSPHATE worse than placebo = -1	4		3	7
DEXAMETHASONE SODIUM PHOSPHATE much worse than placebo = -3	0		0	0
Mean	1.0		1.6	1.3***

*** DEXAMETHASONE SODIUM PHOSPHATE showed statistically significantly greater preference, $P < .001$ (i.e., this value is significantly different from 0 = equal preference)

Overall response to therapy for Periods I and III was evaluated by the investigator and scored on a numerical scale from 1 to 5 (1 = none, 2 = poor, 3 = fair, 4 = good, and 5 = excellent). The mean scores for the 86 patients evaluated are 4.3 for dexamethasone sodium phosphate and 2.4 for placebo. The difference is statistically significant ($P < .001$).

Table I summarizes the data for Period I only. Patients who did not have a given symptom or sign initially were not included in the evaluation of that symptom or sign. Levels of significance are indicated in the table.

The patients were asked to compare their symptoms for each two-week period with their symptoms during the previous year's hay fever season.

Symptoms (see Table 3) were rated as follows: 0 = much improved, 1 = improved, 2 = same, 3 = worse and 4 = much worse. The patients receiving dexamethasone sodium phosphate showed statistically significantly greater improvement than those taking placebo ($P < 0.001$).

Patients in the drug-treated group took from 0 to 4 tablets chlorpheniramine daily (mean dosage of 1.4), and those in the placebo group took 0 to 5 tablets (mean dosage 1.8).

Patients showed consistently less severe symptoms and signs with dexamethasone than with placebo. The

superiority of response to the drug was significant for all symptoms and signs, except for post nasal drip and anosmia after the first week.

A summary of the patients' treatment preferences is shown in Table 4. A significantly greater preference was shown for dexamethasone sodium phosphate ($P < 0.001$).

Discussion

The value of hyposensitization, as specific treatment of fall hay fever, depends on several variables. Experienced allergists obtain good results in approximately 75 per cent of patients. Such variable factors as wind, humidity, temperature changes, and airborne allergen, which may not be clinically significant throughout the year, can cause increased symptoms during hay fever season. Many patients who have benefitted from hyposensitization still require medication for symptomatic relief. It has been our experience that even patients who obtained considerable relief with specific therapy needed symptomatic therapy on certain days of the pollen season.

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cancer forum

The Tumor Registry

WHAT IS THE REAL PURPOSE OF A TUMOR REGISTRY?

Improvement of care of the cancer patient and improvement in the quality of his survival are the real aims of the tumor registry. Hitting this target would fully justify the effort, time and cost involved in operating a registry. Some registries have been very successful. However, despite efforts of the American College of Surgeons, American Cancer Society, state health departments and other agencies, most registries have failed to provide useful assistance.

WHY DO REGISTRIES FAIL IN THEIR PURPOSE?

The most common complaint of physicians about tumor registries is that while much information goes into the registry, nothing he can use ever comes out! There are, of course, many reasons for this. Unless a registry and its procedure is established by medical staff action, it is difficult to involve the physician in a meaningful way. Unless all cancer patients are included in a registry, the information lacks validity. Along with inaccuracy of the statistics, great delay in compilation and difficulty of access to the figures are the final blow.

IN VIEW OF THE ABOVE, ARE THE REGISTRIES WORTH SAVING?

We think so. In addition to their potential for usefulness, two factors have entered the picture that were not present a few years ago. The first is the increasing necessity and acceptance of medi-



Slides are prepared for microscopic examination at a tumor clinic.

cal self audit and the second, the easy access to computer assistance.

WHAT CAN BE EXPECTED FROM A COMPUTERIZED TUMOR REGISTRY?

Such a registry should improve patient follow-up. At stated intervals it would query the physician about his patient and even prepare a recall letter for the physician to send to the patient. Reports from physicians and hospitals would keep the patient's record continually updated. The computer reports would also provide the physician with a comprehensive review of his own treatment results and place these results in proper comparison with the local,

regional and national scene. Hospital tumor boards would also be able to compare their hospital's experience with other treatment centers.

HOW DOES A HOSPITAL SET UP SUCH A PROGRAM?

There are several medical computer programs available in Pennsylvania. Several Regional Medical Programs are exploring this field in cooperation with the Pennsylvania Department of Health. A number of hospitals already are using computers in related fields and this expertise can be easily utilized for programming tumor registries. Information is available from any of the agencies mentioned.



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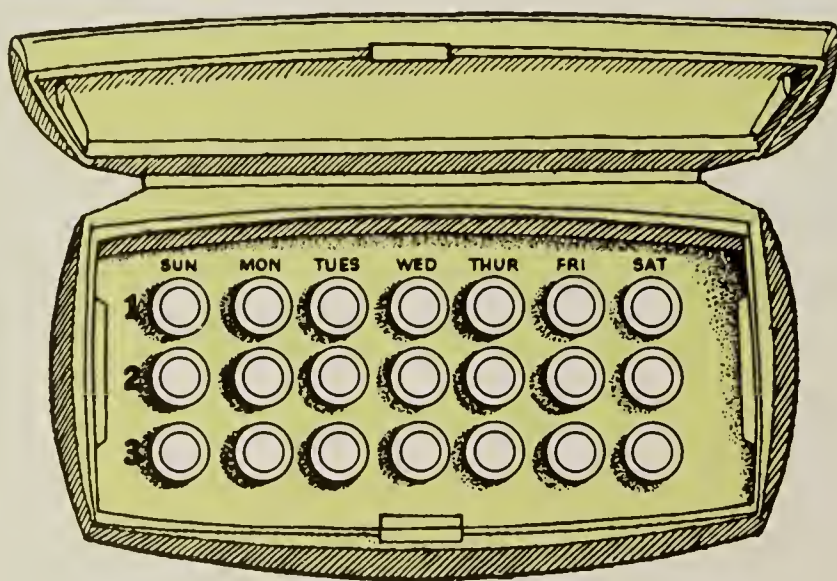
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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid re-

tention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, non-functional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

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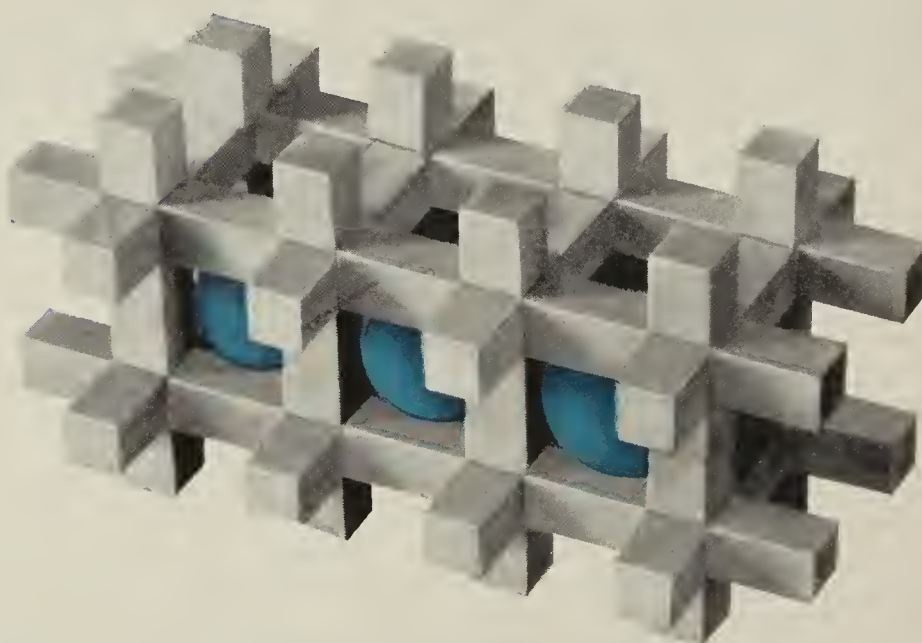
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Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

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duce dosage in proportion to age and weight.

How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.



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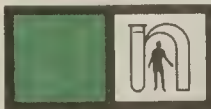
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910



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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



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Specific therapy for night leg cramps



Cardiovascular Surgery - 1970

Thomas J. E. O'Neill, M.D., director of cardiovascular and thoracic surgery, and chief of section, Episcopal Hospital, Philadelphia, is questioned by **William G. Leaman, Jr., M.D.**

From the surgical standpoint, how would you classify cardiovascular diseases?

From the viewpoint of the surgeon, one might consider certain vascular diseases to be grouped under headings such as: (1) congenital: strictures, shunts and anomalous origins or courses, (2) acute injuries: severance and lacerations, (3) degenerative: aneurysms, arteriosclerotic obstructions, and (4) physiologic: arterial spasms. Cardiac lesions may be classified as: (1) congenital defects: constrictions or stenoses of the valves or adjacent valvular tissue, valvular insufficiencies, shunts, atresias or combinations of all, (2) acquired: valvular stenoses, incompetencies or both (largely rheumatic in origin), trauma such as penetrating or crushing wounds with or without residual foreign bodies, (3) degenerative disease: coronary arteriosclerosis, infarctions, myocardial aneurysms, and conduction defects.

From the standpoint of relative incidence, which groups are the most important?

The best classification is by age. We find the overwhelming majority of surgical heart diseases in the first two decades to be congenital cardiac anomalies since such represents the true harvest of genetic misadventure. Acquired heart diseases, such as rheumatic valvular disease and injuries due to trauma, represent the most important types of the third and fourth decades. By the nature of the aging process, the degenerative diseases of the arteries

constitute the principal source after the fourth decade.

How much progress has been made in the surgical treatment of congenital cardiovascular diseases?

Since 1938, after Gross' successful patent ductus ligation, enormous strides have been made in the correction of these anomalies to a point where such defects as patent ductus arteriosus, coarctation of the aorta, pulmonic valve stenosis, atrial septal defect and ventricular septal defect can be cured with a mortality rate of from 5 to less than 1 per cent in experienced hands. Initiated by the work of Blalock and Taussig, the so-called tetralogy of Fallot ("blue baby") was at first palliated by the creation of a systemic-pulmonic shunt operation designated as "Blalock" or its variation, "Potts" operation. This was followed by a more direct palliative operation (removing the pulmonic outflow obstruction, either valvular or infundibular) and then finally, with the advent of open-heart surgery in 1956, the first total repair of tetralogy of Fallot was accomplished. It is now established that total repair should be the operation of choice, with operative mortality of 15 per cent or less in the average case. Extensive research is being carried out to correct the more difficult, but less numerous, anomalies such as truncus arteriosus, tricuspid atresia and transposition of the great vessels with limited, but improving, success. Some rare, almost unbelievable monstrosities, will probably elude solution forever.

What is the present status of surgery for acquired heart disease?

In the realm of traumatic heart and vessel disease, the surgeon usually deals with the repair of torn and fragmented myocardium and/or major associated

blood vessels. One can judge from the fact that 90 per cent of the patients operated upon for these assaults leave the hospital on their own power. It is almost axiomatic that the patient brought to the hospital alive suffering with cardiovascular trauma should leave the hospital alive and sound in the great majority of instances. Rheumatic valvular diseased patients are mainly victims of chronic disease, and they are afforded a comprehensive work-up, probing their cardiopulmonary, renal and hepatic functions by the use of advanced testing technics, the keystone of which is all-chamber cardiac catheterization and cineangiography complemented with dye and gas studies. More recently, we have profited by the introduction of echograms to assess more adequately structure and motion variations. These studies combine to produce an exceedingly accurate picture of the patient's structural, as well as functional, derangements which is invaluable for the surgeon's preparation and execution of his repair. Using open-heart surgery, it is not possible to relieve obstructive stenoses, and, in more recent years, to remove the entire diseased valve and replace it with a prosthetic one of thoroughly tested and acceptable characteristics. Lately there have been reports of three-valve replacements, the early success of which supports the hope of achieving greater longevity and lessened morbidity for these sufferers. The operative mortality ranges from 15 per cent for the one-valve replacement to 30 per cent for the three-valve replacement. The need for replacement is far greatest for the mitral valve, lesser for the aortic and least for the tricuspid valve.

William G. Leaman, Jr., M.D. edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.



○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Joseph T. Beardwood, Jr.**, Philadelphia; University of Pennsylvania School of Medicine, 1921; age 73; died April 11, 1970. He was an author, a founder and a past president of the American Diabetes Association. He is survived by two sons, one of whom is Donald M. Beardwood, M.D., a daughter and a sister.

○ **Martin E. Blutinger**, Carversville; Medical College of Georgia, 1959; age 42; died February 1, 1970. Surviving are his wife and two daughters.

○ **Jacob R. Brobst**, Bloomsburg; Jefferson Medical College, 1915; age 78; died March 24, 1970. He served in the Medical Corp in World War II, and was Columbia County Coroner. He is survived by his wife and two brothers.

○ **Alfred J. Catenacci**, Merion Station; Hahnemann Medical College and Hospital, 1938; age 58; died April 1, 1970. He was an author, as well as director of the division of anesthesiology at Hahnemann Medical College and Hospital. Surviving are his wife, a son, two daughters, three brothers and four sisters.

○ **Harry C. Hackman**, East McKeesport; University of Michigan, 1916; age 79; died April 7, 1970. He served in the Army during World War I. Surviving are his wife and son.

○ **David Katz**, Pittsburgh; University of Pittsburgh School of Medicine, 1920; age 75; died April 13, 1970. He was a specialist in gynecology and a former president of the Allegheny County Medical Society. He is survived by a son, David L. Katz, M.D., a daughter and three sisters.

○ **Joseph E. Kent**, Bethal Park; George Washington University, 1934; age 63; died April 2, 1970. He is survived by his wife and three sons.

○ **Thomas Klein**, Bala-Cynwyd; Medico-Chirurgical College of Philadelphia, 1913; age 78; died April 18, 1970. He served as a former chief of medicine at the Presbyterian Univer-

sity Medical Center. Surviving are his wife and two sons.

○ **W. Newton Long**, York; University of Pennsylvania, 1915; age 79; died April 8, 1970. He served in the Navy during World War I and in World War II served as medical adviser to the local selective service board. He was a specialist in internal medicine. His wife and two sons survive.

○ **George Major**, Reading; Temple University School of Medicine, 1928; age 66; died April 14, 1970. Surviving are his wife, a sister and two brothers.

○ **Hugo Mella**, Arlington, Va. University of Georgia School of Medicine, 1913; age 81; died in March, 1969, the exact date is uncertain. No survivors are listed.

○ **Clifford J. Murdoch**, Carnegie; Harvard University, 1925; age 72; died April 1, 1970. He is survived by his wife, a son, two brothers and two sisters.

○ **Thaddeus S. Nowinski**, Wilkes-Barre; Hahnemann Medical College, 1947; age 49; died April 3, 1970. He served in the Army in World War II and in the Air Force during the Korean War. Surviving are his wife, a son and two sisters.

○ **James P. Ramsey**, Philadelphia; Howard University College of Medicine, 1939; age 59; died April 6, 1970. He served as the first Negro flight Surgeon in the Army Air Corps during World War II. His wife, three brothers and two sisters survive.

○ **Carl A. Rilling**, Philadelphia; Hahnemann Medical School, 1935; age 59; died March 15, 1970. During World War II, he served in the Army Medical Corps, and was a past president of the board of directors of the Pennsylvania Mineralogical Society. He is survived by his wife, a daughter and two sons, one of whom is David C. Rilling, M.D.

○ **Peter J. Schettino**, McKees Rocks; Georgetown University School of Medi-

cine, 1914; age 56; died April 16, 1970. He is survived by his wife.

○ **Alvin A. Schlegel**, Pittsburgh; University of Pennsylvania School of Medicine, 1915; age 83; died March 23, 1970. He specialized in ophthalmology. He is survived by two brothers and a sister.

○ **Alexander M. Usher**, Boca Raton, Fla.; University of Toronto, 1926; age 72; died March 26, 1970. He served in the Canadian Army during World War I. Surviving are his wife, a brother, Charles Usher, D.D.S., and a sister.

○ **John E. Weigel**, Pittsburgh; University of Pittsburgh School of Medicine, 1924; age 72; died April 10, 1970. He had served as president of the Passavant Hospital's medical staff, and also was a former president of the Southwestern Chapter of the American College of Surgeons. He received a Certificate of Approval from President Dwight D. Eisenhower for his service as chairman of the Allegheny County Medical Advisory Committee to the Selective Service System. Surviving him are his wife and four sons, three of whom are doctors, Jessie A. Weigel, M.D., John E. Weigel, M.D., and A. Linn Weigel, M.D., and a brother.

○ **Edwin R. Wiese**, Waynesboro; John Hopkins University School of Medicine, 1911; age 83; died January 29, 1970. No survivors are listed.

○ **Homer A. Wilson**, Salem, Va.; University of Pittsburgh School of Medicine, 1912; age 90; died March 9, 1970. He specialized in obstetrics. His wife, a daughter, two brothers and a sister survive.

○ **Newton G. Allebach**, Souderton; Jefferson Medical College, 1913; age 82; died February 2, 1970. Surviving are his wife and three daughters.

○ **William T. Branen**, Yeadon; University of Pennsylvania School of Medicine, 1933; age 63; died March 7, 1970. He specialized in obstetrics and gynecology, and at one time served as the Methodist Hospital president. Survivors include his wife and a daughter.

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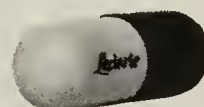
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PENNSYLVANIA
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meetings

AUGUST

Germantown Academy Annual Symposium on Sports Medicine, August 13-14, 1970, Germantown Academy Ft. Washington, Pa.

SEPTEMBER

Eastern Pennsylvania Chapter, American College of Surgeons, Conference, September 10-11, 1970, Shawnee-on-Delaware, Pa. Contact Harry G. Light, M.D., Secretary, 65 E. Elizabeth Ave., Bethlehem, Pa. 18018.

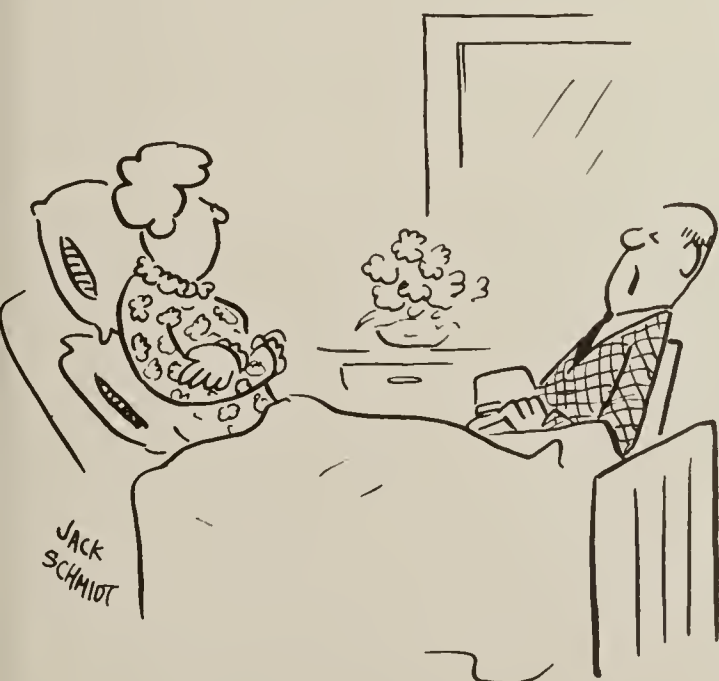
Conference on Suffering and Death, Noon to 4 P.M., Thursday, September 17, 1970, Boyd Memorial Center, 234 South St., Harrisburg. For advance information or reservation contact: Rose Levonian, Conference Coordinator, Boyd Memorial Center, 234 South St., Harrisburg, Pa. 17101.

OCTOBER

Pennsylvania Medical Society 1970 Annual Business Session, October 4-8, 1970, Host Farm Resort Motel, Lancaster.

NOVEMBER

Pennsylvania Medical Society Annual Scientific Assembly, November 16-19, 1970, Host Farm Resort Motel, Lancaster.



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PENNSYLVANIA
MEDICINE

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A survey of the rural practices has been compiled by Bond L. Bible, Ph.D., secretary of the AMA Council on Rural Health, and published in *Public Health Reports*, Vol. 85. Copies are available from the AMA Department of Community Health, 535 North Dearborn St., Chicago, Ill. 60610.

More Than Skin Deep, a comprehensive book on beauty and health, written by Thomas H. Sternberg and published by Doubleday & Company, Inc., deals with the skin cosmetically, the internal problems affecting the skin, and skin diseases and their treatment.

Ayerst Laboratories now has a film available for medical groups interested in estrogen replacement therapy. The film, *The Long-Range Problems of the Postmenopausal Woman*, is a color/sound film running forty-three minutes.

Smith Kline and French has recently released its *SK&F Services Catalogue 70/71*. Included in the illustrated catalogue are medical films, booklets, pamphlets, periodicals and the "Code 4" cardiopulmonary resuscitation training program. Free copies are available by contacting the SK&F Representative, or by writing to the Services Department E-10, Smith Kline and French Laboratories, 1500 Spring Garden St., Philadelphia, Pa.



PHYSICIANS WANTED

Needed: Staff Physicians, Internists and Generalists, for modern 2,100-bed Chronic Disease and Rehabilitation Hospital. Located eight miles from heart of city and universities. Dynamic rehabilitation program. Board certified consultants available in all specialties. University affiliations. Five-day, thirty-five hour week. Salary competitive and negotiable. Paid vacations and holidays. Pension plan, insurance and other fringe benefits. Contact John J. Kane Hospital, Allegheny County Institution District, G. P. Hamill, M.D., Director, Vanadium Road, Pittsburgh, Pa. 15243.

Physician in general medicine wanted—Active 200-bed G M & S hospital. Liberal vacation, sick leave, health benefits and retirement plan. Board certified or qualified preferred. GP with good background in internal medicine considered. U. S. citizenship preferred; license any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Altoona, Pa. 16603.

Looking for a decent place to raise your family? Take a look at God's Country. Golden opportunity for General Practitioners and OB-Gyn. Specialists interested in private practice or association. Write: Administrator, Columbia Hospital, Columbia, Pa. 17512.

Residency—Child Psychiatry—(two years) Academically and analytically oriented. 1,000 bed general hospital. Individual supervision given. Director and supervisors certified in child psychiatry and child psychoanalysis. Training built on knowledge of normal development through observations and on extensive individual diagnosis and therapeutic experience with full range childhood problems. Through integrated affiliations, work with psychosis, mentally defective, and organically damaged children and also work in school system and comprehensive pediatric program. Opportunity for research. Close proximity psychoanalytic training facilities. Five weekly conferences. Salary \$7,000 to \$12,000+ depending on year. Opportunities for additional

stipends available. Apply Irwin Lyons, M.D., Director of Training, Child Psychiatry, Albert Einstein Medical Center, York & Tabor Roads, Philadelphia, Pennsylvania 19141.

General Practitioner: Consider locating in growing Western Pennsylvania, in Darlington area, Beaver County. New industries. Two Hospitals in Beaver Falls, fifteen minutes away. Turnpike ten minutes away. Contact J. B. Swick, Darlington, Pa. 16115.

Emergency Room Physician; central Pennsylvania; 175-bed hospital. Pennsylvania license required. Near Pennsylvania State University. Salary negotiable. Contact Richard West, Administrator, Centre Community Hospital, Bellefonte, Pa. 16823. Telephone (814) 355-4801 collect.

Physicians wanted: male and female, licensed, for children's camps, July-August. Good salary; free placement; 350 member camps. Write: Dept. P, Association Private Camps, 55 W. Forty-second St., New York, N. Y. 10036. Telephone (212) OX 5-2656.

Emergency Department Physicians—D.O. or M.D., Pa. registered. Four wanted to cover around clock and calendar. Salary. Contact Administrator, Lewistown Hospital, Lewistown, Pa. 17044.

Family Practice Residency—St. Margaret Memorial Hospital, Pittsburgh, Pa. Openings available July 1 for one first-year and two second-year residents

(internship year will be considered as fulfillment of first year). Stipend \$9,840-\$10,440-\$11,040. Fringe benefits. Contact: George E. Cramer, M.D., Director of Family Practice Residency, St. Margaret Memorial Hospital, Pittsburgh, Pa. 15201.

House Physicians (two)—Immediate opening for a 208-bed J.C.A.H. approved hospital. Positions open for day and evening shifts. Must have a Pennsylvania license. Salary \$15,000. Apply to Mr. E. F. Mallon, Jr., Asst. Administrator, Sacred Heart General Hospital, Chester, Pa. 19013.

Anesthesiologist—Board eligible. To join modern, well-organized and staffed department in medium-sized Philadelphia hospital. Primarily a supervisory position. Minimum calls from home. Substantial benefits including multiple paid fringe benefits and ample time for vacation and continuing education. Replies received in confidence. Write: Z-62, P.O. Box 2066, Philadelphia, Pa. 19103.

Internists, General Practitioners, Pediatricians. Wanted for group medical practice in inner-city Philadelphia. Prefer those interested in social change. Competitive salary, fringe benefits and faculty appointment to medical school for qualified physicians. Please contact: Mr. Harold A. Burks, 3701 N. Broad Street, Suite 812, Philadelphia, Pa. 19140.

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House physician wanted: 221-bed general hospital. Pennsylvania license required. Salary negotiable. Position available now. Contact Medical Director, Frankford Hospital, Philadelphia 19124. JE 3-9400.

Pathologist needed: Medical services firm located in Philadelphia area interested in an energetic, imaginative pathologist who will lead its division of Cellular Pathology and who intends to advance this area of laboratory medicine by the development of new methods and concepts. Send resume to Department 578, PENNSYLVANIA MEDICINE.

Urgently needed: General Practitioner, fully accredited hospital; 70 beds, construction for new wing late summer. Contact Administrator, Community Hospital, Kane, Pa.

Immediate openings for house physicians - as of July 1, 1970. 274 bed accredited general hospital. Write: Office of Administrator, Lower Bucks Hospital, Bristol, Pennsylvania.

Child Psychiatrist—Board Eligible—to head child Psychiatric services in progressive, expanding, comprehensive mental health center in the city of Philadelphia. Dynamic, creative, imaginative and daring individual wanted.

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Psychiatrists and physicians—Accredited hospital; approved psychiatric residency program, affiliated with approved general hospital. \$17,839 to \$25,115; housing possible. Pennsylvania license required. R. L. Gatski, M.D., Director, State Hospital, Danville, Pennsylvania 17821.

Emergency room physician—full time; Accredited 300 bed general hospital; active approved internship and residency programs; excellent benefits. Submit resume to: Administrator, Robert Packer Hospital, Sayre, Pa. 18840.

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in my opinion Embryo Physicians

Last month I attended part of the annual convention of The Student American Medical Association. It was most instructive. By and large these young people are very intelligent and very concerned with human health in all of its widest aspects.

This kind of concern, when they oppose so many things older people tend to take for granted, is often called radicalism. Actually these delegates reflected the full spectrum of political opinion from left to right. It is true, however, that the whole picture was somewhat more liberal than the position of the AMA House of Delegates.

An important observer from medical organizations had a disturbing reaction. He related the more unusual hair, beard, and costume styles to extreme political views, placing great emphasis on his pleasure at finding some individuals with a traditional appearance.

I believe that this is far from a valid inference. People of all ages affect costume and hair styles for varied reasons. Among others, these would include family, racial, and national influences, pressure from peer groups, and economic necessity. On the personal side, odd styles could stem from an attempt to break family ties, to create a noteworthy appearance, or mere personal taste. None of these reasons denotes political leanings or moral standards. We agree that generalization by religion, race and sex are individious. When

we say that a man is a mean Scotchman, a dissolute Frenchman, or a lazy Mexican, we know that we are unfair to the many of those peoples who do not have that characteristic. We can be losers if we choose to prejudge candidates for friendship on such grounds. "I wouldn't trust a Limey with a plugged nickel," or "I wouldn't have a dumb Swede in my house," means that the speaker is limiting his human relationships by other than reasonable grounds. It is like saying "I won't be friends with anyone whose name begins with M or who lives in a house with an even number."

On a limited experience it is my observation that many wildly coiffured medical students wearing unusual types of clothing are most interesting and thoughtful people. I have also seen some extremely radical young people who dress like bank clerks.

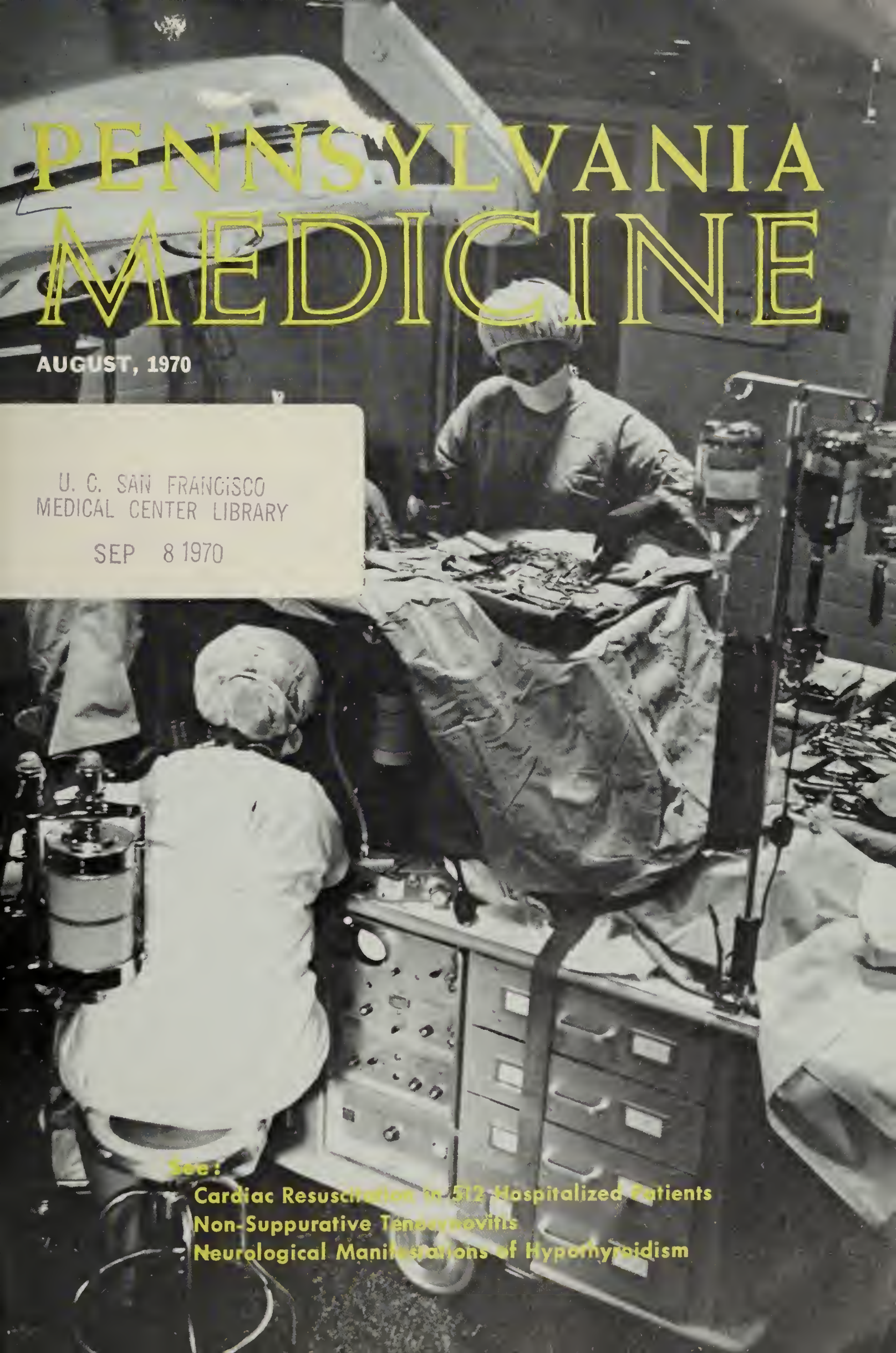
These kids are going to provide medical care to America of the future. As many of our styles differ from the '20's or the Edwardian or Victorian periods, they will differ outwardly in some respect from us. The medicine that they practice will differ from the medicine of today also. The approach and the dedication of tomorrow's physicians will, I think, be essentially the same.

George A. Rowland, M.D., Editor
Columbia County Medical Society Bulletin

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● Installation of William A. Limberger, M.D., as the 121st President of the Pennsylvania Medical Society.

● Presentation of the past president's medallion to William A. Barrett, M.D., 120th President.

● Presentation of Distinguished Service Award to Eugene P. Pendergrass, M.D.

● Presentation of State Benjamin Rush Awards.



PENNSYLVANIA
MEDICINE

/medigram

AUGUST, 1970

PMS FORMS LAY ADVISORY COMMITTEE

PMS President William A. Barrett, M.D., has announced that seven prominent Pennsylvania laymen have accepted appointments to a committee to give the State Society non-medical opinions about health care matters. He said the committee was formed in the hope that it would be able to assist physicians in finding ways to improve health care for state residents. The committee elected its own chairman and vice-chairman and is reviewing material in preparation for a meeting in October. Committee members are: George L. Cullen, vice-president--personnel, Strawbridge and Clothier, Philadelphia; Charles H. Watts, II, Ph.D., Litt.D., L.L.D., president, Bucknell University, Lewisburg; Rev. Paul M. Washington, rector, Church of the Advocate, Philadelphia; Patrick M. Greene, Harrisburg, director, Community Services Committee, Pennsylvania AFL-CIO; J. Quint Salmon, attorney, Beaver; Mrs. John M. Spatz, Pittsburgh, General Federation of Women's Clubs and State Senator John H. Ware, Oxford. Mr. Cullen is the committee chairman, and Dr. Watts is vice-chairman. William A. Limberger, M.D., West Chester, PMS president-elect, is assigned to the committee. The committee will select its own topics for discussion and will present recommendations directly to the Board of Trustees.

RURAL HEALTH CONFERENCE SLATED

The State Society will sponsor the Pennsylvania Conference on Rural Health, a one-day meeting aimed at educating rural communities to meet health care needs, on September 18, 1970, at the Penn Harris Motor Inn, Camp Hill. Donald E. Harrop, M.D., Phoenixville, chairman of the PMS Advisory Committee on Rural Health, will preside. Katherine B. Hess, M.D., of the Pennsylvania Department of Health, will speak following the luncheon. Bond L. Bible, Ph.D., secretary of the AMA Council on Rural Health will close the program with a summation and charge.

SECOND FAMILY PRACTICE EXAMS ANNOUNCED

The American Board of Family Practice has announced that the second round of examinations for certification in the new specialty will be held in centers throughout the country February 27 and 28, 1971. Information on the examination and eligibility can be obtained by writing to: Nicholas J. Pisacano, M.D., Secretary-Treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506. Deadline for receiving completed applications is November 1, 1970.

GOVERNOR SIGNS PROFESSIONAL CORPORATIONS ACT

Governor Raymond P.
Shafer on July 9

signed into law the Professional Corporations Act, which by its terms becomes effective on August 8. This new law will strengthen both the tax and non-tax advantages of a physician's incorporating, but legal counsel has warned that it should not be given greater significance than it deserves. The Professional Corporations Act, Act No 160 of 1970, was described briefly in the May issue of PENNSYLVANIA MEDICINE in an article by Leif C. Beck, Esq. entitled, "An Updated Look at Professional Corporations." Mr. Beck, of the law firm of Pepper, Hamilton and Scheetz, Philadelphia, is preparing an article analyzing the act as finally adopted and its effect on Pennsylvania physicians. The article is scheduled to appear in the September issue.

ETV OFFERS SERIES ON MEDICINE

A ten-week series concerning medicine's role in society is being broadcast on a number of Pennsylvania educational television stations. The programs are being shown Saturday evenings at 6:30 p.m. The first in the series appeared July 25. The remainder of the schedule is as follows:

August 1: A Health Policy for the 70's, with Massachusetts Senator Edward F. Kennedy as guest.

August 8: Determining the Future of Medical Care.

August 15: Educating the Consumer.

August 22: Organized Medicine: the AMA, with Ernest B. Howard, M.D., AMA Executive vice-president, as guest.

August 29: Medical Research: Some Aspects Which Warrant Public Understanding.

September 5: The Needs of Medical Education.

September 12: Science Writing, Physicians and the Public.

September 19: Why Does Medical Care Cost So Much?

September 26: The Future of Medical Communications.

The series is being carried on WITF-TV, Hershey; WLTV, Allentown; WQLN, Erie, and WVIA-TV, Scranton.

PMS REPRESENTED AT HEARINGS

Matthew Marshall, Jr., M.D., Pittsburgh chairman of the PMS Council on Medical Service, testified for the State Society before the United States Senate Finance Committee at its recent hearings on Medicare and Medicaid.

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AUGUST, 1970

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The cover photograph shows Maxcart in use at Pennsylvania Hospital, Philadelphia. See the relating article on page 45.

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week after week.**

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**and monial
overgrowth this week.**

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin
where bacteria end.

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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

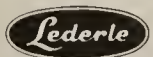
Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.



decision:



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moderately severe
infections*

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*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

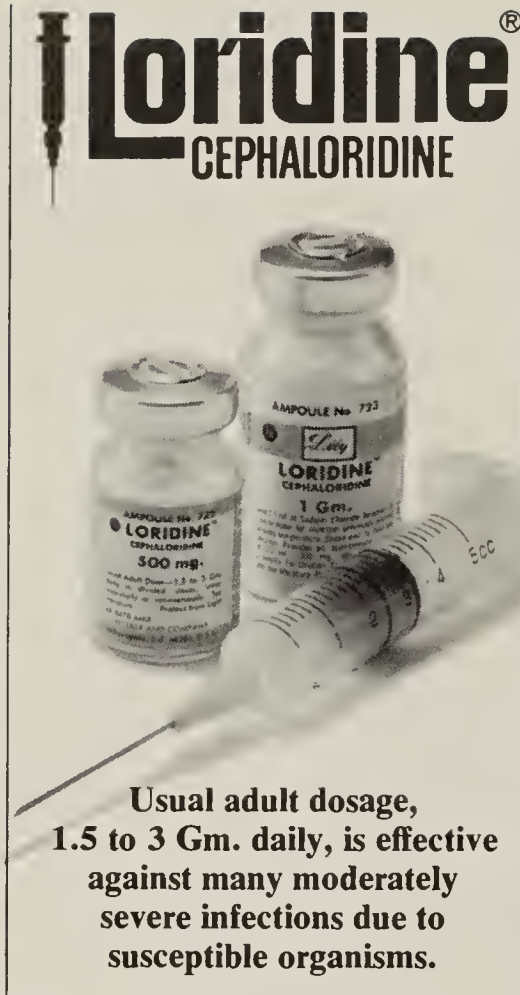
Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some case terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

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Pa. Delegates In Key AMA Actions

Pennsylvania's delegation to the AMA House of Delegates played a key role in the recent record-setting session in Chicago.

From the stormy beginning of a public forum reference committee to the time from House Speaker Russell B. Roth, M.D., of Erie, banged the closing gavel, the House considered a record 201 reports, resolutions and recommendations that ranged from abortions to the destiny of the AMA itself. AMA dues were increased \$40 to \$110.

To thwart disruptions planned for the opening session, the AMA held a first — a simultaneous public reference committee hearing at which any group or person were invited to express views. William Y. Rial, M.D., of Swarthmore, speaker of the PMS House, was a member of the special committee and another Pennsylvanian, Louise C. Gloeckner, M.D., of Conshohocken, vice-president of the AMA, served as a resource person.

The Pennsylvania Delegation, with Thomas W. McCreary, M.D., of Rochester, as chairman, held daily breakfast meetings to plan action on the various items before the House, including support of the three resolutions it introduced and the many candidates for offices.

Election-wise, Dr. Roth was re-elected AMA speaker and Dr. Gloeckner, whose term as vice-president ended at the session, was elected a member of the Council on Constitution and Bylaws.

At council reorganization meetings, William A. Sodeman, M.D., of Philadelphia, was elected chairman of the Council on Medical Education and Elmer G. Shelley, M.D., of Erie, was re-elected chairman of the Judicial Council.

The three Pennsylvania resolutions were: One calling on the AMA to establish criteria and a special category

of AMA membership for personnel in the allied professions, which was slightly amended and then adopted; another calling on the AMA to begin public affairs TV programming on a regular basis, which was referred to the Board of Trustees; and a third in memory of the late Edward Bortz, M.D. of Philadelphia, of the AMA, which was passed by acclamation.

Pennsylvanians also served as members of regular reference committees. They included: William A. Barrett, M.D. of Pittsburgh, PMS President; and Malcolm W. Miller, M.D., of Philadelphia. John B. Lovette, M.D., of Johnstown, served on the Committee on Rules and Order of Business.

Kevin J. Boran, of Minersville, International Science Fair winner, and his parents, Mr. and Mrs. James Boran, were guests of the Pennsylvania Delegation at an open house. Kevin spoke to the delegation at its opening meeting and received an AMA Health Awards citation at a special banquet.

All of Pennsylvania's delegates and eight of the alternate delegates were present for all or parts of the session.



In conference above, left to right, are John F. Rineman, PMS executive director; William A. Limberger, M. D., president-elect, and Thomas W. McCreary, M. D., chairman of the PMS delegation. Below, David Keck, M. D., and George Rowland, M. D., confer.



The Pennsylvania delegation held a breakfast caucus each morning. Shown above is a table of delegates. Additional caucus photos are on page 10.

York Hospital Hailed by AMA

The AMA House of Delegates in Chicago gave special recognition to the 145 physicians on the staff of the York Hospital for being the first hospital staff in the nation to have all of its members qualify for the AMA Physician's Recognition Award for Continuing Education. The presentation was made by James Z. Appel, M.D., of Lancaster, past president of the AMA, and the House responded with an ovation. Donald E. Piper, M.D., of York, accepted for the hospital staff.



Raymond C. Grandon, M. D., center, PMS secretary, chats with delegate Wilbur E. Flannery, M. D., left, and Leo Brown, of the AMA staff. Below, left, are two breakfast caucus photos.



Dr. Hartman Named To AMA Position

John F. Hartman, M.D., of Erie, director of medical education at St. Vincent Hospital and past president of the staff, assumed duties with the Council on Medical Education of the American Medical Association. One of the functions of the council is the inspection and evaluation of various hospitals, their facilities and training programs for the approval of internships and residencies in the various specialties. Dr. Hartman has been active in the affairs of the Pennsylvania Medical Society and had served as chairman of the Council on Public Service for ten years. For the past three years he has been a member of the Pennsylvania State Board of Medical Education and Licensure.

Pa. Ladies Appointed To Auxiliary Posts

Mrs. Manuel A. Bergnes, Norristown, was elected to a two-year term as director of the Woman's Auxiliary to the American Medical Association at the forty-seventh annual convention held late in June. Mrs. Bergnes will also serve as chairman of the Home-Centered Health Care Committee for the national auxiliary. Mrs. Robert F. Beckley, Lock Haven, was elected bylaws chairman of the auxiliary at the convention. Mrs. Beckley has served two terms as treasurer and previously served three terms as eastern regional vice president.



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PMS Visits Nation's Lawmakers

More than a score of PMS physicians and related personnel participated in the overnight congressional contact visit to Washington arranged by the Council on Governmental Relations.

The physicians chatted with members of the state's congressional delegation in their offices, in anterooms off the House floor where the postal pay increase was being debated and at a special reception in the evening of their first day in the nation's Capitol.

In addition to the exchange of information and views between physicians and members of the US House and Senate, the State Society group received a briefing on the Washington political scene from members of the staff of the Washington office of the AMA. The AMA presentation, coordinated by Harry R. Hinton, deputy director of the AMA public affairs division, was made at a luncheon that started the visitation program. It concluded the following morning with a breakfast where Robert H. Craig, executive assistant to the PMS Council on Governmental Relations, led a discussion to share experiences and the information gained in the visits with individual members of the Congress.

The reception the preceding evening was attended by about fifty persons



President-Elect William A. Limberger, M.D., West Chester, chats with Representative Joshua Eilberg of Philadelphia and Philip Ingaglio, M.D., Philadelphia.

including more than a dozen congressmen, Senator Richard S. Schweiker and key members of the congressional staff.

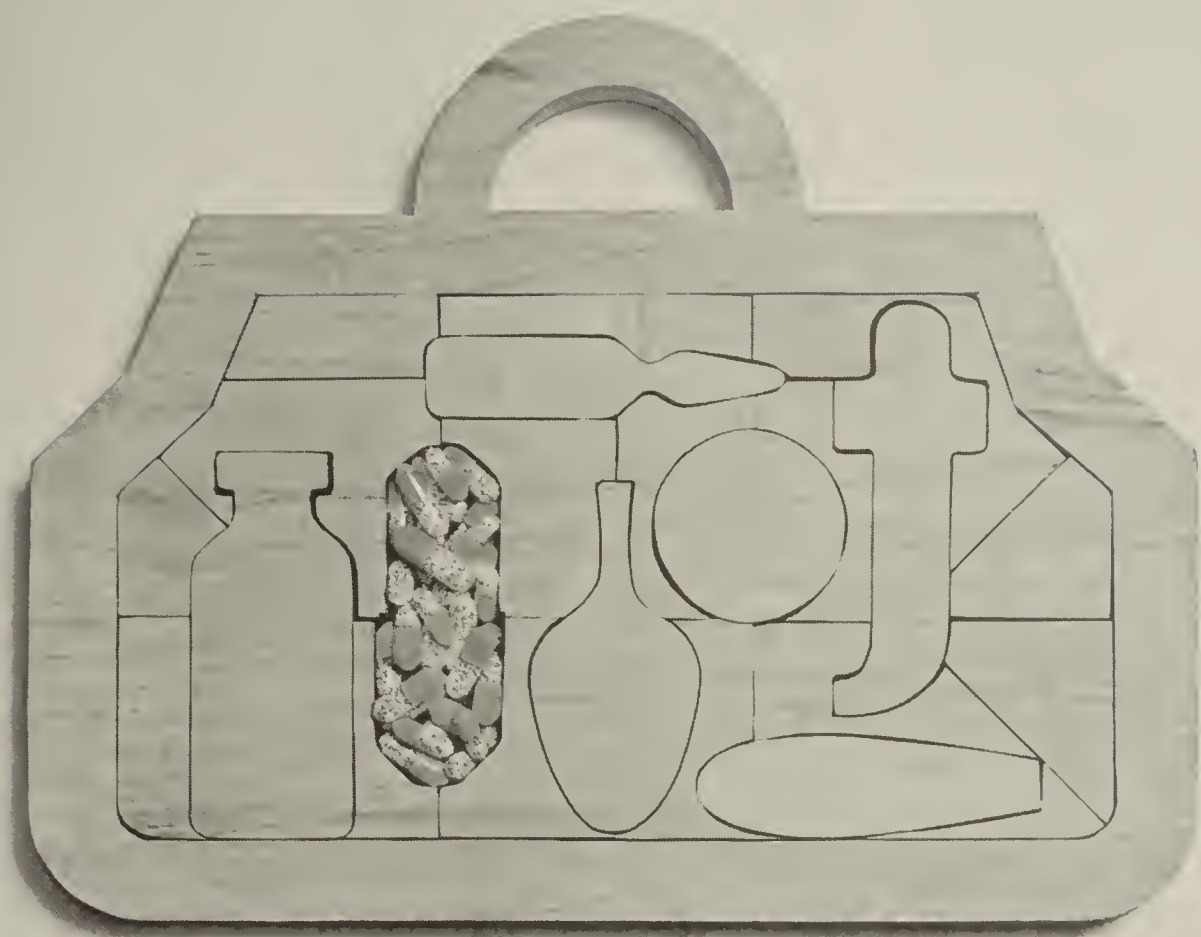
The fact that many congressmen took time out of a busy and demanding floor debate on the postal bill to visit

with members of the Pennsylvania group was regarded by most participants as an indication of respect for the growing physician involvement in government affairs.

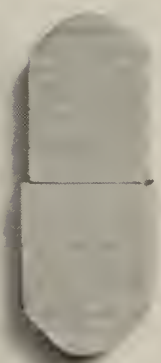
(See additional pictures on page 14.)



Washington visitors receive briefing from AMA staff members at a luncheon.



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An exchange of ideas takes place at the Capitol between, above left, PMS President William A. Barrett, M.D., Pittsburgh, and Representative Robert J. Corbett, Allegheny County. (lower left) Representative John P. Saylor of Johnstown and John B. Lovette, M.D., Johnstown and (above) Senator Richard S. Schweiker, William R. Hunt, M.D., Pittsburgh, and Marshall E. Johnson, M.D., of Aliquippa.

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Representative William S. Moorhead, Allegheny County, Robert J. Carroll, M.D., of Pittsburgh (above left), and George E. Farrar, M.D., Philadelphia and Representative F. Lawrence Coughlin, Montgomery County (above right), all take part.

Sports Medicine Meet is Set

Some 100 professionals concerned with the health needs of school athletes will converge on Germantown Academy's Fort Washington campus Thursday and Friday, August 13 and 14, for the fourth annual Symposium on Sports Medicine. The Pennsylvania Medical Society is a co-sponsor.

The symposium will bring together physicians, nurses, coaches, trainers and other professionals from all parts of the country.

"This annual conference, providing

for an exchange of the latest information on meeting the medical needs of college and secondary school athletes, is an outgrowth of our concern for the development of the total student," David G. Moyer, M.D., academy medical director and symposium chairman, said.

Covering all aspects of sports medicine, the agenda includes panel discussions, question and answer sessions, exhibits, films and lectures. Physicians will receive credit hours from the American Academy of General Practice.

Eight M.D.'s Appointed

Eight family physicians from the Hershey Hospital staff have been appointed as clinical instructors in family and community medicine in the College of Medicine at Milton S. Hershey Medical Center of Pennsylvania State University.

While remaining in private practice at their own offices, these physicians become the only doctors to date who will have direct admitting privileges to the hospital at the Medical Center while not being on the medical school's full-time, salaried faculty.

They are Drs. D. L. Backenstose, L. G. Fetterman, J. O. Hewlett and H. H. Stauffer, of Hershey, and Drs. R. R. Curanzy, R. N. Eckroth, H. H. Engle, and G. H. Hoffman, of Palmyra.

In announcing the appointments, George T. Harrell, Jr., M.D., dean and director, pointed out that Hershey Estates has been planning to close the Hershey Hospital as a community hospital when the medical center's 350-bed hospital opens in October, thus causing a change in the pattern of hospitalization in the immediate area.

One Serves Many Schools

The American Medical College Application Service (AMCAS) has developed a centralized application service which should be of value to applicants, medical schools and undergraduate schools. The program is set up in such a way that the applicant to participating medical schools need only file one application and one set of official transcripts regardless of the number of schools to which he is applying. This year two Pennsylvania medical schools are participating in the program. They are the University of Pittsburgh School of Medicine and Temple University School of Medicine. The AMCAS service fee will be charged according to the number of participating medical schools to which the applicant wishes to apply. The student applying to one school will pay \$10.00; two schools, \$15.00; and up to four, five and six schools, \$25.00.

Woman's Changes Name

The Woman's Medical College of Pennsylvania has been officially renamed the Medical College of Pennsylvania, and its hospital, the Hospital of the Medical College of Pennsylvania. The name change came about as a result of the September, 1969 decision by the board to admit men to the medical program.

In 1850 women were barred from the study of medicine until a small group of men, believing women should have equal opportunities in pursuing medical careers, began the Female Medical College of Pennsylvania. In 1867 the name was changed to Woman's Medical College of Pennsylvania.



The third Physician/Nurse Seminar sponsored by the Pennsylvania Medical Society, the Pennsylvania League of Nursing and the Pennsylvania Nurses Association was held recently at PMS headquarters. Malcolm W. Miller, M. D., chairman of the Committee on Relationships with Allied Professions, conducted the seminar. Pictured below are, left to right, Dr. Miller, Mrs. Elizabeth Groff, Pennsylvania League of Nursing, and Dorothy J. Novello, Ph. D., of the Pennsylvania Nurses Association.



Elizabethtown Has Birthday

This year the State Hospital for Crippled Children at Elizabethtown celebrates its fortieth year of service to the handicapped children of Pennsylvania. The hospital is operated by the Pennsylvania Department of Health as part of its Division of Maternal and Child Health, has 205 beds and an extensive schedule of out-patient clinics and conferences to service all types of handicapped children. It meets three primary needs in that it serves as a regional diagnostic and treatment center to the State Health Department's Crippled Children's Program, it is an out-patient center to which patients may be referred from any physician or clinic in Pennsylvania for definitive diagnosis, evaluations and recommendations concerning juvenile amputees, cerebral palsy patients, lower extremity deformities, non-surgical disorders requiring rehabilitation and neurological disorders. The hospital is also equipped for extensive in-patient treatment and surgery.

Department Completes Study of Cirrhosis

Results of a Health Department study completed last month indicate that liver cirrhosis mortality is directly related to alcohol consumption and that, probably, the most important underlying contributing factor is diet.

The one-year study, which was completed last month, was based on liver cirrhosis mortality figures in Pennsylvania since 1950. Members of the Health Department's Division of Research and Biostatistics who completed the study were George K. Tokuhata, M.D., director; Edward Digon, chief, Biostatistical Research; and Krishnan Ramaswamy, biostatistician.

Per capita alcohol sale by each county was significantly correlated with the cirrhosis death rate only where the degree of urbanization was either high or low, but not in the intermediate area.

In the two most urban counties, Philadelphia and Allegheny, the average per capita alcohol sale for 1960 was almost three times (\$60) that in the least urbanized areas (\$21); likewise the cirrhosis death rate was almost three times greater in the two metropolitan counties (15 per 100,000) than in the least urban counties (6 per 100,000).

The cirrhosis death rate was at least two times higher in the "fifty per cent or more" urban areas (13 per 100,000) as compared with that in the "less than twenty-five per cent" urban areas (6 per 100,000). This difference coincides with similar differences in average per capita alcohol sales.

From a standpoint of income, it was found that the average (per capita) sale of alcohol was approximately the same for the middle income and low income groups. The death rate for cirrhosis was much higher, however, in the low income groups indicating that diet might be a contributing factor. Also noted was a significant correlation between per capita alcohol consumption and liver cirrhosis mortality rate in the low income group, but not in the middle income group. People in the high income group consumed much more alcohol per person and the cirrhosis death rate was also high.

In addition, while there was a



George E. Way, M.D., left, president, Northampton County Medical Society exchanges views concerning regional medical care service with William F. Boucher, M.D., president of the Lehigh County Medical Society, Representative Fred B. Rooney of the Fifteenth Congressional District and Gordon Barrow, M.D., coordinator, Georgia Regional Medical Program, at the recent joint meeting of Lehigh and Northampton County Medical Societies. The guest speaker at the meeting was Representative Fred B. Rooney.

correlation between alcohol consumption and liver cirrhosis deaths, the rate of deaths did not increase as much as that of the net (adjusting for inflation) increase in per capita alcohol consumption. This also indicates the presence of another or other important causative factors.

Cirrhosis mortalities increased consistently only in whites in Pennsylvania. Nutritional improvement among Negroes in recent years could be responsible for this discrepancy.

Cirrhosis deaths increased only among men, suggesting that the frequency and/or the absolute amount of drinking may not have increased substantially among women in recent years.

A marked difference in the median age at death was shown between the cases with mention of alcoholism and those without mention of alcoholism. Those with alcoholism died much younger (55.3 years) as compared with those without (61.0 years).

Cirrhotic patients, as an entire group, died at least ten years younger than would be expected. The median age of death from liver cirrhosis in this state in 1960 was 59.3 years; while the median age at death from all other causes was 69.7 years, also in 1960.

The relative importance of liver

cirrhosis as a cause of death (in the presence of other competing risks of life) was highest in the twenty-five to twenty-nine year age group. While these deaths are apparently not associated with alcoholism, further studies are indicated to identify specific factors which could explain such findings.

Dr. Tokuhata remarked that if diet, as it appears from the study, is of particular significance in the development of liver cirrhosis, an effective program of prevention and therapy for this liver disease could be within reasonable reach. Furthermore, he continued, the economic losses — in productivity and medical costs — due to this disease could be lessened through preventive and therapeutic measures.

County Society Gives Info

A series of public information programs was presented by the Berks County Medical Society and the Heart Association of Midwestern Pennsylvania this summer. The theme of the seminar concerned itself with facts about heart attack and aids in their prevention. Nutrition and weight control, stop smoking clinics and physical fitness were all a part of the discussions.



First, there were
tranquilizers for
anxiety



Then, there were
antidepressants for
depression

NOW, Pfizer Laboratories introduces

Sinequan

DOXEPIN HCl

The tranquilizer that is
an antidepressant.

The antidepressant that is
a tranquilizer.

The first single agent with potent
dual action...active throughout the spectrum
of psychoneurotic anxiety/depression



New Sinequan® (doxepin HCl)... in coexisting anxiety/depression

142 patients with symptoms of both anxiety and depression were treated with Sinequan—83% of the patients showed marked, moderate, or slight improvement.

TARGET SYMPTOMS	TOTAL	NO. OF PATIENTS IMPROVED	IMPROVEMENT			% OF PATIENTS IMPROVED
			MARKED	MODERATE	SLIGHT	
anxiety/depression	142	118	39	46	33	83%

In three double-blind studies comparing Sinequan and a fixed combination (perphenazine-amitriptyline), Sinequan was found to be at least as effective as—and in some cases more effective than—the combination.

New Sinequan... in prominent anxiety

238 psychoneurotic patients in whom anxiety was the most prominent symptom were treated with Sinequan—84% of the patients showed marked, moderate, or slight improvement.

DIAGNOSIS	TOTAL	NO. OF PATIENTS IMPROVED	IMPROVEMENT			% OF PATIENTS IMPROVED
			MARKED	MODERATE	SLIGHT	
psychoneurotic anxiety	238	201	92	59	50	84%

In eight double-blind studies of Sinequan and either chlordiazepoxide or diazepam, Sinequan was always found to be at least as effective as—and in some cases more effective than—the tranquilizers in relieving symptoms of anxiety.

New Sinequan... in prominent depression

259 psychoneurotic patients in whom depression was the most prominent symptom were treated with Sinequan—81% of the patients showed marked, moderate, or slight improvement.

DIAGNOSIS	TOTAL	NO. OF PATIENTS IMPROVED	IMPROVEMENT			% OF PATIENTS IMPROVED
			MARKED	MODERATE	SLIGHT	
psychoneurotic depression	259	210	106	72	32	81%

In five double-blind studies of Sinequan and amitriptyline, Sinequan was always found to be at least as effective as—and in some cases more effective than—the antidepressant in relieving symptoms of depression.

Data on File, Medical Research Laboratories, Pfizer Pharmaceuticals, Chas. Pfizer & Co., Groton, Conn.
Summary of clinical experience with Sinequan (doxepin HCl) in, Pitts, N.: The Clinical Evaluation of Doxepin—A New Psychotherapeutic Agent: Psychosomatics 10:164, May-June, 1969.

Adverse reactions:

Sinequan (doxepin HCl) is usually well tolerated, even in the elderly. Those side effects which do occur are generally mild.

Most frequently observed side effects

Drowsiness has been observed, usually early in the course of therapy. It tends to disappear as therapy continues.

Anticholinergic effects (including dry mouth, blurred vision, constipation) have been reported. They are usually mild and often subside with continued therapy or reduction of dose.

Infrequently observed side effects

Extrapyramidal symptoms have been infrequent and have usually occurred at high dose levels. They tend to be mild and easily controlled.

Cardiovascular effects, such as hypotension and tachycardia, have been reported infrequently.

Other infrequently reported side effects include dizziness, nausea, increased sweating, edema, nasal congestion and weight gain.

Sinequan is noneuphoriant, and no dependence has been reported to date.

Safety:

Liver disorders, blood dyscrasias, lens opacities or pigment deposits in eyes or skin have not been reported to date with Sinequan.

Contraindications:

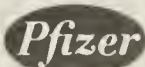
Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention.

Warnings:

Sinequan should not be used concomitantly or within two weeks of therapy with MAO inhibitors.

Sinequan should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient. Its use in children under 12 years of age is not recommended because safe conditions for its use have not been established.

(See last page for full adverse reactions, contraindications, warnings and precautions.)



LABORATORIES DIVISION
New York, N. Y. 10017

Recommended dosage:



Starting dosage—
25 mg., t.i.d.
Maximum dosage—
300 mg. per day.

Expected activity:

Antianxiety activity is rapidly apparent, comparable to that of the benzodiazepine tranquilizers. Antidepressant activity is comparable to the tricyclic antidepressants.

How supplied:

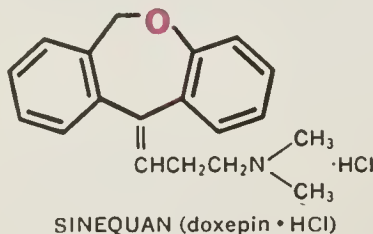
Bottles of 100 capsules of 10 mg., 25 mg., and 50 mg.; bottles of 1000 capsules of 25 mg. and 50 mg.



SINEQUAN (Doxepin·HCl) Capsules

Description. SINEQUAN (doxepin·HCl) is a new dibenzoxepin psychotherapeutic agent with marked antianxiety and significant antidepressant activity.

Chemistry. SINEQUAN (doxepin·HCl) is a dibenzoxepin derivative and is the first of a new family of psychotherapeutic agents. Specifically, it is an isomeric mixture of N,N-Dimethyl-dibenz(b,e)oxepin- $\Delta^{11(9H)}$, γ propylamine hydrochloride.



Indications. In a carefully designed series of controlled studies, SINEQUAN (doxepin·HCl) has been shown to have marked antianxiety and significant antidepressant activity. SINEQUAN (doxepin·HCl) is recommended for the treatment of:

1. Patients with psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Alcoholic patients with anxiety and/or depression.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic depressive reactions.

The target symptoms of psychoneurosis that respond particularly well to SINEQUAN (doxepin·HCl) include anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

In those patients in whom anxiety masks the depressive state, SINEQUAN (doxepin·HCl) is of particular value since it exerts a potent antidepressant effect as well as antianxiety activity.

Patients who have failed to respond to other antianxiety or antidepressant drugs may benefit from treatment with SINEQUAN (doxepin·HCl).

Clinical experience has shown that SINEQUAN (doxepin·HCl) is safe and well tolerated even in the elderly patient.

In a large series of patients systematically observed for withdrawal symptoms, none were reported. This is consistent with the virtual absence of euphoria as a side effect and the lack of addiction potential characteristic of this type of chemical compound.

Contraindications. SINEQUAN (doxepin·HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

SINEQUAN (doxepin·HCl) is contraindicated in patients with glaucoma, or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* SINEQUAN (doxepin·HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of SINEQUAN (doxepin·HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors

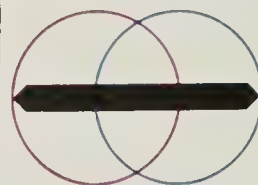
NEW

Sinequan®

DOXEPIN HCl



Starting dosage:
25 mg. t.i.d.



The first single agent that can be prescribed as a tranquilizer, an antidepressant...or both

should be discontinued at least two weeks prior to the cautious initiation of therapy with SINEQUAN (doxepin·HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of the possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although SINEQUAN (doxepin·HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g. iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. SINEQUAN (doxepin·HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, SINEQUAN (doxepin·HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, SINEQUAN (doxepin·HCl) does exert a significant blocking effect. In addition, SINEQUAN (doxepin·HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients, an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology, or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. SINEQUAN (doxepin·HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin base in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

Issued September 1969

Pfizer

LABORATORIES
DIVISION

New York, N.Y. 10017



After only one year:
Administered
to more people
than live in
Erie and
Harrisburg.*

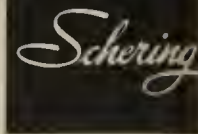


Injectable
Garamycin[®]
brand of gentamicin sulfate
injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Erie and Harrisburg is 207,000.
(Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Injectable Garamycin[®] brand of gentamicin sulfate injection



ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	Less Severe 0.8-1.2 mg./kg. for 7-10 days	Resistant/ Moderately Severe Larger doses or additional antibac- terial therapy should be consid- ered in severe urinary tract infec- tions or in resistant cases involving the renal parenchyma or anatomic anomaly.	Serious/Life- Threatening
Other Infections including bacter- emia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		up to 5 mg./kg.

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by:				No. of <i>In Vitro</i> Studies
		4 mcg./cc. or less	(%)	8 mcg./cc. or less*	(%)	
<i>Staphylococcus aureus</i>	1,210	1,200	(99%)	1,206	(99%)	11
<i>Pseudomonas aeruginosa</i>	885	771	(87%)	828	(93%)	16
<i>Escherichia coli</i>	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative <i>Proteus</i> species	477	210	(44%)	358	(75%)	12
<i>Klebsiella-Aerobacter</i> species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa*, 828 (93%); *Escherichia coli*, 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.

Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa*, *Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.



Joseph T. Freeman, M.D., Philadelphia, chairman of the Commission on Geriatrics for the Pennsylvania Medical Society, recently took part in a symposium sponsored by the Regional Medical Program for Western New York directed toward geriatric medicine.

M. Louise Gloeckner, M.D., vice-president of the American Medical Association has been awarded an honorary life membership certificate by the board of directors of the American Cancer Society, Philadelphia Division. Dr. Gloeckner resides in Conshohocken.

Luther W. Brady, M.D., Philadelphia, has been named professor and chairman of the Department of Radiation Therapy at Hahnemann Medical College and Hospital of Philadelphia.

Nicholas M. Nelson, M.D. has been appointed professor and chairman of pediatrics in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University. Dr. Nelson is currently assistant professor of pediatrics at Harvard University Medical School, senior pediatrician and acting director of the Laboratory for Neonatal Research at Boston Hospital for Women, and chief of the newborn division of Children's Hospital Medical Center in Boston. He is also an associate editor of the *New England Journal of Medicine*.

Waldo Treuting, M.D., of the University of Pittsburgh Graduate School of Public Health, has received an award of merit from the Pennsylvania Public Health Association for his outstanding contribution to public health. Dr. Treuting is also chairman of the Western Pennsylvania Comprehensive Health Planning Group.

Robert J. Wolfson, M.D., Philadelphia, an authority on micro-surgery of the ear, has been named professor and head of the section of otolaryngology at the Women's Medical College of Pennsylvania. He has published many medical journal articles.

Stanley J. Brody, M.D., Wyncote, associate professor in community medicine and psychiatry at the University of Pennsylvania, recently received the

second annual Governmental Achievement Award given by the Philadelphia chapter of the American Society for Public Administration.

Malcolm H. McGavran, M.D., has been appointed professor of pathology in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University. Dr. McGavran has studied and published extensively in the field of human neoplasia. His major contributions have been in the studies of cancer of the larynx and adjacent areas, and in a variety of skin tumors.

George I. Blumstein, M.D., Philadelphia, received the Distinguished Service Award of the American Academy of Allergy at the recent annual meeting in New Orleans.

George G. Burkley, M.D., a cardiologist and personal physician to three presidents, Dwight D. Eisenhower, John F. Kennedy and Lyndon B. Johnson, has recently retired to an ancestral home in Blairsville. Dr. Burkley is a native of Pittsburgh and was a graduate of the University of Pittsburgh School of Medicine. He is a former Naval doctor and served at Walter Reed Army Medical Center where he met President Eisenhower. During President Johnson's term of office Dr. Burkley was promoted to vice admiral. He is the second physician to receive that rank. **Walter R. Tkach, M.D.**, head of a three man clinic, is the primary physician serving President Richard M. Nixon. Dr. Tkach is also a graduate of the University of Pittsburgh School of Medicine.

John C. Maerz, M.D., Norristown, has been promoted to director of clinical research and services at McNeil Laboratories, Inc.

Vincent G. Stenger, M.D., an authority on the effects of anesthesia on the human fetus and newborn infants, has been named professor and chairman of obstetrics and gynecology in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University.

Harold H. Rotman, M.D., specialist in pulmonary diseases was elected a fellow in the American College of

Physicians. He is chairman of the Respiratory Care Committee at the Albert Einstein Medical Center and has recently received a grant from the Schering Corporation of \$36,960 to study a new type of bronchodilator.

Audrey Evans, M.D., oncologist at The Children's Hospital of Philadelphia, recently was presented the Woman of the Year Award from the Philadelphia council of auxiliaries of the American Medical Center at Denver. Dr. Evans is being honored for her efforts at increasing government funds for cancer research. She is also associate professor of pediatrics at the University of Pennsylvania School of Medicine.

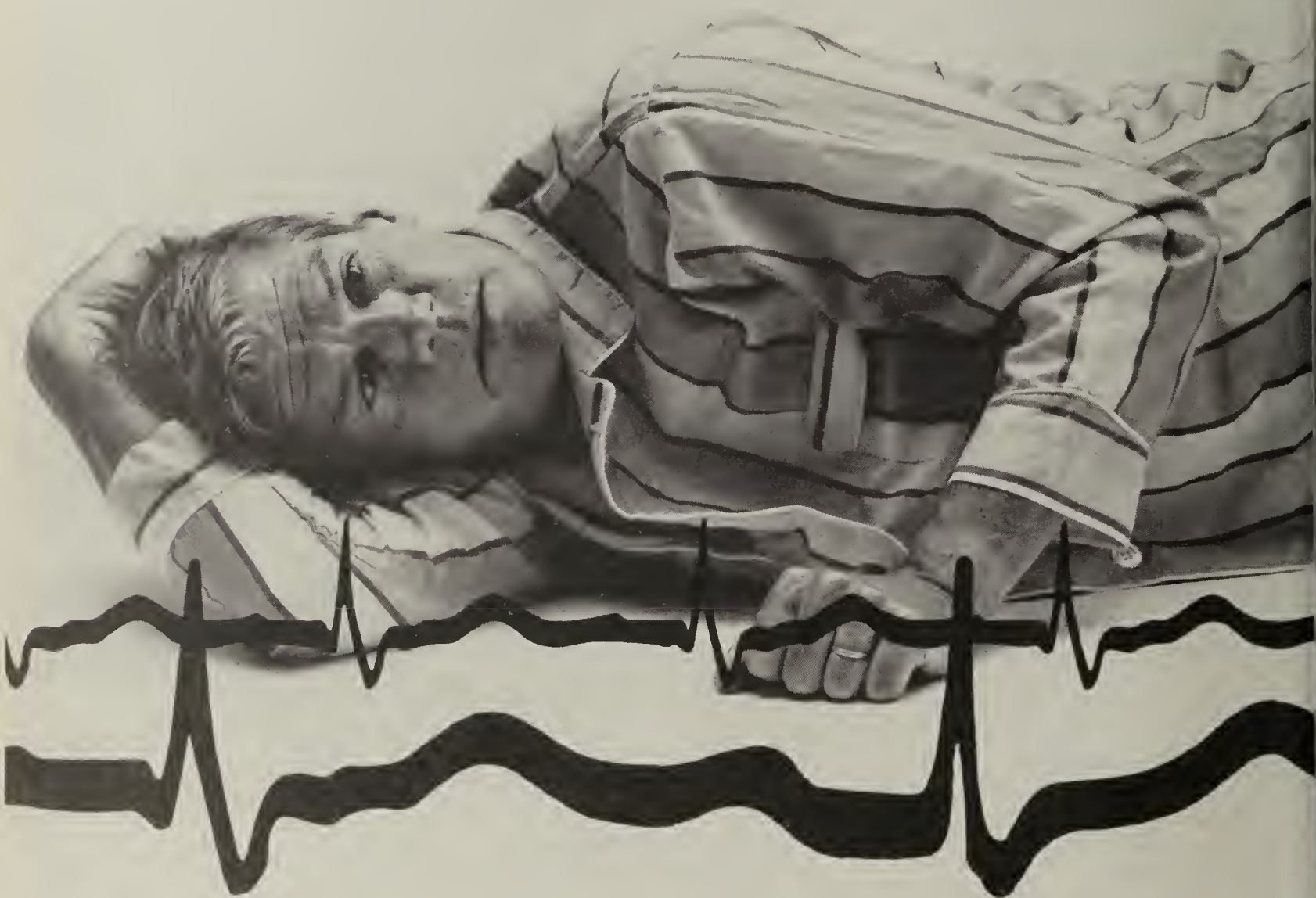
G. Frank O. Tyers, M.D., Hershey, has been appointed professor of surgery in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University. He recently completed a residency in cardiothoracic surgery at the University of Toronto. He will continue his research interests in coronary artery disease and cardiac pacemaking.

Leonard Bachman, M.D., director of the division of anesthesiology at The Children's Hospital of Philadelphia recently took part in the Tunisian tour of Project Hope.

John J. Gartland, M.D., Philadelphia, has been appointed the new James Edwards Professor of Orthopaedic Surgery, Jefferson Medical College and chairman of the department of orthopaedic surgery at Thomas Jefferson Hospital. He is internationally known in the field of orthopaedic surgery and has done extensive research in bone repair. He has published both articles and books, and is currently associate editor of *The Journal of Bone and Joint Surgery*.

Ronald A. Chez, M.D., professor of obstetrics and gynecology at the University of Pittsburgh, has been appointed associate dean for academic affairs at Pittsburgh's School of Medicine. He will supervise three major programs: postgraduate medical education, medical education evaluation and inquiry, and medical education media.

Night of the Cardiac



Sleeplessness may produce additional difficulties in victims of heart disease. This "cardiac insomnia" can debilitate the patient—particularly the geriatric heart patient—to such degrees as to cause reduction of stamina and endurance, with possible loss of some physiologic function. To further the problem, the heart patient often becomes a "sleep cripple" as he spends a good portion of the night listening to his heart beat with a morbid reluctance to fall asleep.

When this problem remains unresolved, it may intensify his heart condition. It may even complicate treatment and delay recovery.

Noludar[®] 300 (methyprylon) CAPSULES **for the rest of the night**

Noludar 300, a nonbarbiturate sedative-hypnotic, promptly induces sleep that can last 5 to 8 hours. Usually within 45 minutes, it helps provide a good night's rest for the insomniac generally without morning-after grogginess or drug "hang-over." Moreover, paradoxical excitation rarely occurs—



an important advantage in the cardiac and elderly.
Noludar 300 (methypylon): For the relief of insomnia at home, in the hospital, or in the nursing home. One capsule at bedtime—for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates

and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-gripping. Chewable. Very palatable. Economical.

EVAC-U-GEN[®]

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.

PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.



SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society
in recent months:

ARMSTRONG COUNTY:

Paul L. Frederick, M.D., 206 N. Jefferson St., Kittanning 16201.

BLAIR COUNTY:

William H. Dumeyer, M.D., Altoona Hospital, Altoona 16603.
Arch W. Fees, Jr., M.D., 501 Howard Ave., Altoona 16601.

CENTRE COUNTY:

Paul H. Wengrovitz, M.D., 251 Easterly Pkwy., State College 16801.

CHESTER COUNTY

Geraldine A. Mowbray, M.D., Lincoln Univ., Lincoln University 19352.
Robert E. Damiano, M.D., Wyeth Labs., P. O. Box 8299, Philadelphia 19101.

DAUPHIN COUNTY:

Fouad A. Geadah, M.D., 1100 N. Second St., Harrisburg 17102.
Robert R. Tompkins, M.D., 21st & By-pass, Camp Hill 17011.

CHESTER COUNTY:

Maurice M. Davidson, M.D., 2 Chester Pike, Ridley Park 19078.
Leonard C. Giunta, D.O., 304 E. Lancaster Ave., Downingtown 19335.

GREENE COUNTY:

Richard D. Hasz, M.D., 1535 Sixth St., Waynesburg 15370.

HUNTINGDON COUNTY:

Jorge M. Gonzales, M.D., Blair Hospital, Warm Spring Ave., Huntingdon 16652.

LANCASTER COUNTY:

Alistair M. Grant, M.D., 737 College Ave., Lancaster 17603.

LEHIGH COUNTY:

Michael A. M. Rea, M.D., 21 N. 20th St., Allentown 18104.

MERCER COUNTY:

Richard J. Brevetta, M.D., 14 Porter Way, Sharon 16146.

Gulan H. Moonda, M.D., 912 E. State St., Sharon 16146.

Nanette D. Quaglio, M.D., 14 Porter Way, Sharon 16146.

MONROE COUNTY:

Brian M. Gottlieb, M.D., 125 Stokes Ave., Stroudsburg 18360.

Zarko D. Milich, M.D., 32 N. Green St., E. Stroudsburg 18301.

MONTGOMERY COUNTY:

Ruth E. Buck, M.D., 109 Erdenheim Rd., Philadelphia 19118.

Abraham A. Lurie, M.D., 328 Strathmore Dr., Rosemont 19010.

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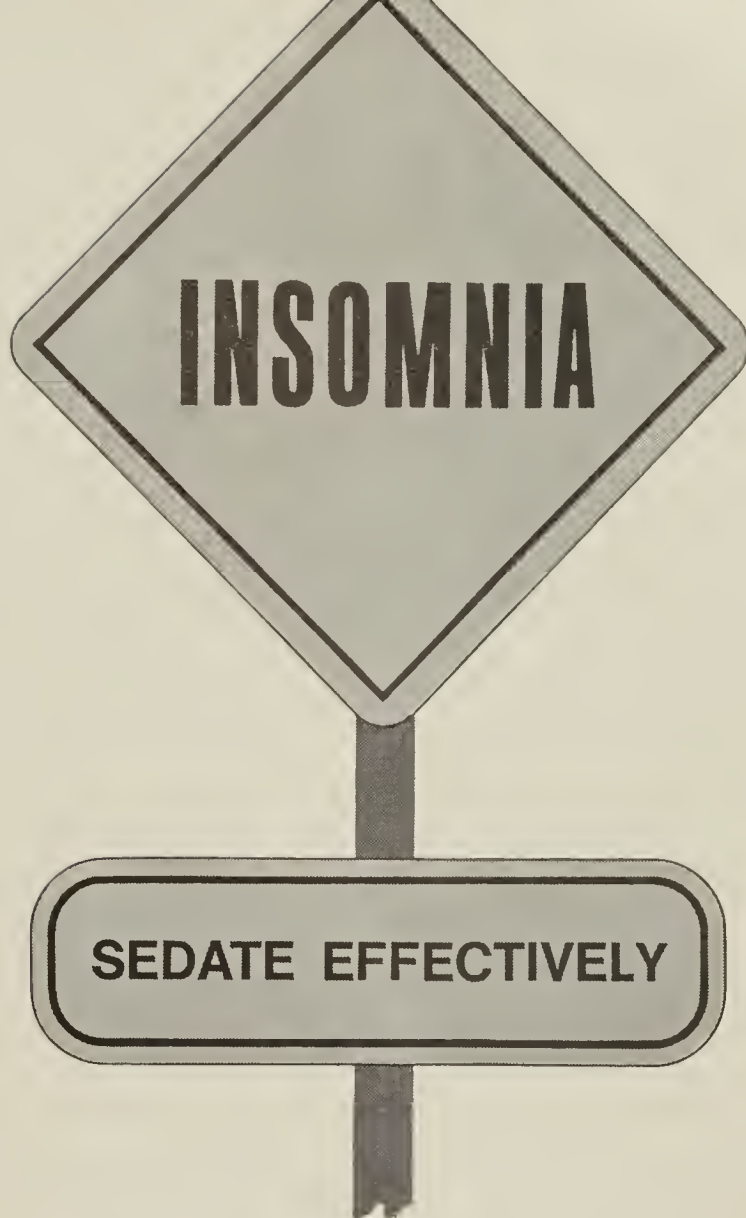
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T. R. Miller, M.D., Director
Student Health Service
Edinboro State College
Edinboro, Pa. 16412

Re: Ankle Sprains

Dear Dr. Miller:

As you know, in a college with an enrollment of approximately 6,500, with hundreds of students engaged in major sports, a sprained ankle is a very common occurrence. These incidents occur at all hours of the night and day and on all days of the week. The diagnosis by physical examination between a sprain and a fracture can become a problem.

To this end, during the past year, in taking care of non-athletes and as team physician for the multiple sports program at Edinboro State College, I have made the following observations and conclusions:

1. In inversion injuries of the ankle (most common injury of all) with the absence of any obvious gross deformity of the ankle; a fracture of the lateral aspect of the ankle joint is NOT present:
 - a. IF the point of maximum tenderness is just anterior to the distal end of the fibula.
 - b. IF there is little tenderness on pressure *over* the lateral aspect of the distal fibula.
 - c. IF there is exaggeration of pain by forced inversion of the ankle joint with the ankle joint in plantar flexion, AND very little exaggeration of the pain by forced inversion of the ankle joint with the ankle in the neutral position.

While these may or may not be Florek's triad, I have correlated these signs closely enough with x-ray findings during the past year to feel that they approximate 100 per cent in accuracy in ruling out fractures of the lateral aspect of the ankle joint.

Sincerely yours,
F. F. Florek, M.D.
Edinboro, Pa.

March 17, 1970

Dr. Matthew Marshall, Chairman
Council on Medical Service
Pennsylvania Medical Society
Taylor Bypass and Erford Road
Lemoyne, Pa. 17043

Dear Dr. Marshall:

I should like to request the consideration of the Council of Medical Service for the following proposal. I suggest that the Council on Medical Service recommend to the administrations of Blue Cross and Blue Shield in Pennsylvania that all restrictions be discontinued for maternity care of female policy holders except for a reasonable delay after enrollment as for any pre-existing illness.

It is my contention that pregnancy is as much a calculable risk to health as is any other cause for hospitalization. At the present, handling of this situation is not statistically

honest. Not only are many unmarried female policy holders uncovered for this risk but many married women who do pay for the coverage are not exposed because of surgical sterilization, other physical conditions precluding pregnancy, or post menopausal status.

I feel that this is a definite inequity in the policies of these insurers. There are several other ways in which the situation could be corrected but it seems to me that bringing maternity out of its special category for all females would be the simplest and least expensive arrangement.

Sincerely yours,
G. A. Rowland, M.D.
Trustee and Councilor
Fourth District, Pennsylvania

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1970 ANNUAL SESSION

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A Beginning At Politics

There is a good deal of evidence that many physicians would be active in political life if they felt more "at home," more confident, in this kind of activity. They do not know how to make a start without suffering embarrassment. Considerable help is present for these physicians from the PAC movement. In a series of pamphlets ("Political Action Series") which may be obtained by writing to the American Medical Political Action Committee at 520 North Michigan Avenue, Chicago, Ill. 60611, or by calling 312-644-1585, there are very specific instructions.

But it is probable that my editorializing will not produce an avalanche of requests for AMPAC. It seems that physicians are unable to take that first step, possibly because they fear the unknown and especially the unknown extent to which they may become involved.

But all of us *can* take that first step at being useful. Pamphlet number one in the series cited above points out that all of us must learn about politics at home, in our own community because that is where politics *is*. Moreover, we will learn what we already know, namely that we must do our own studying and that it must begin on a small scale.

Recommendations for this self study are interesting. We

are urged to learn material which ought to be known to every citizen: about the subdivisions of government, about precincts and wards and legislative districts. We must study how the vote runs, based on what groups live in what areas and how they vote. We must make the acquaintance of those who lead the parties and we must learn what the real local issues are.

Much of the material for your primary political education may be had from your public library and, incidentally, it might be a valuable by-product to visit it once again. Political office holders will gladly further your education and talking with knowing neighbors, with education in mind, can be highly informative.

Not only your local libraries but the publications of your own political party can be helpful to your primary political education.

And if you get stuck, write to AMPAC at the address given above. Better yet, keep it local and call or write to PAMPAC, Post Office Box 295, Lemoyne, Pa., 17043. Telephone: 717-238-8344. Your request for help will get you a surprisingly warm response.

Reverse Psychology

The antic attacks of "revolutionaries" on "the establishment" might be having the opposite of the intended effect, according to research reported in *Psychology Today* by William J. McGuire, Ph.D., of Yale University. Opposite, that is, if they really want to change the system. Dr. McGuire's experiments showed people tend to be vulnerable to attacks against beliefs they have never seriously questioned, like: "you should have your chest x-rayed regularly." He wanted to use "capitalism is good" as one of the test beliefs but could not find enough students holding that opinion strongly enough.

Weak arguments, however, especially when delivered in a threatening way, seemed to make the subjects hold to their beliefs more strongly. The weak dose, when presented with threat, seemed to inoculate the experimental subjects against change. On the other hand, stronger arguments presented in a reassuring way created the greatest change in belief.

The wildhaired revolutionaries, who threaten many of us with their appearance alone, have some pretty good arguments for change. But their failure to do their homework, their emphasis on anger, obscenity and silly behavior, might tend to "inoculate" many of us against being persuaded. At least that's what we infer from Dr. McGuire's work.

Clarence C. Smith
Public Relations Consultant



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A Diagnostic Dilemma

Non-Suppurative Tenosynovitis



Fig. 1. Flexion of affected finger only.



Fig. 2. Subsequent full flexion of all fingers.

EUGENE S. KILGORE, JR., M.D.
San Francisco
and
WILLIAM P. GRAHAM, III, M.D.
Philadelphia



Fig. 3. Attempt at extension of fingers as a group producing "triggering" of the affected finger.



Fig. 4. Pain on direct pressure over the volar aspect of the metacarpal head.

Non-suppurative tenosynovitis is often described in the texts for surgery of the hand as the "trigger" phenomenon. Little mention is made of the variable etiology of this condition and less attention is devoted to the diagnosis of this often incapacitating malady in the absence of "triggering."

Etiology

Acute direct trauma causes this problem in only a small proportion of patients. Women, particularly those who are employed in industry, have a greater incidence of non-suppurative stenosing tenosynovitis.² Often the patient performs unusual motions rapidly thus producing repeated undue strain upon tendons and ligaments.

Repetitive trauma appears to be a great part of the etiology of this disability. The flexor pollicis longus and the other digital flexors are usually involved at the narrow area under the

TABLE I
TENDONS FREQUENTLY INVOLVED BY
NON-SUPPURATIVE TENOSYNOVITIS

Flexor pollicis longus (may be congenital)	
Extensor pollicis brevis	} de Quervain's disease
Abductor pollicis longus	
Flexor superficialis ring finger	} often combined involvement
Flexor superficialis long finger	

annular band in the region of the metacarpal heads. The carpal tunnel is a second area of constriction and at times the extensor tendons under the extensor retinaculum on the dorsum of the wrist may be affected. (Table I)

Edema and inflammation of the tendon sheath in the area of these constrictions occurs early. Progression of the process causes thickening of the tendon and its sheath. Eventually, insufficient space remains beneath the pulley for the free gliding of the tendon and locking on flexion or extension results.

The greatest proportion of the patients (75 per cent) suffering from non-suppurative stenosing tenosynovitis will have no isolated antecedent cause.

Miscellaneous metabolic causes (15 per cent) can form a basis for the production of non-suppurative tenosynovitis. Rheumatoid disease can cause this phenomenon when it progresses to the point of degeneration of the tendons. Although some authors comment on the "rheumatoid tendency" to characterize acute isolated episodes of tenosynovitis, it is unlikely that this represents true rheumatoid arthritis. Bunnell in the third edition of his text¹ quotes, "A relationship between tenosynovitis, trigger finger, Dupuytren's contracture and rheumatoid disease."

Other metabolic disturbances such as gout and the collagen disorders may become manifest with an acute tenosynovitis. The diagnosis of these underlying problems depends on the astuteness of the physician.

Diagnosis

A complaint of non-specific and often non-localized pain in the hand with little other history should alert the physician to the possibility of non-suppurative tenosynovitis. The pain may be aggravated by certain motions or particular

positioning of the hand. Occasionally the only complaint is aching pain at the lateral region of the proximal interphalangeal joint with digital motion. Careful examination of the extremity with the patient sitting in a relaxed attitude is imperative after a thorough complete history has been obtained.

The "trigger" phenomenon may be palpable rather than visible. Special motions may be required to elicit it. If ordinary flexion and extension do not produce this effect, the affected finger can be drawn down into acute flexion with the other fingers extended. (Fig. 1) Subsequent flexion of all of the fingers (Fig. 2) followed by an attempt at extension will often produce the "triggering" effect. (Fig. 3)

Pressure over the metacarpal head at the level of the proximal flexion pulley with the production of pain is diagnostic. (Fig. 4)

Palpable thickening and swelling in the area of flexor tendons as they pass beneath the flexor retinaculum at the wrist may also suggest the diagnosis. Occasionally crepitus is felt over the tendons.

Treatment

The diagnosis may be further substantiated by the initial treatment. The injection of a small amount of steroid (preferably triamcinolone) in a local anesthetic with complete relief of pain confirms the physician's suspicions. At times, one or two injections may be sufficient to alleviate the symptoms com-

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pletely. When, however, the symptoms return rapidly after injection or are not completely relived by the treatment, release of the offending pulley or the constricting retinaculum is necessary.

Immobilization, elevation and intermittent warm compresses may improve the patient's condition, but such symptomatic treatment is less effective than local injection. These measures may be helpful adjuncts in the therapy of these patients and a certain number of patients will have a spontaneous resolution of their disability without treatment.

If the proper diagnosis is made and treatment instituted with the injection of steroids, less than one-half of the patients with this problem will require subsequent surgery.

When surgery becomes necessary, a release of the proximal flexor pulley by direct incision and a longitudinal incision in the tendon sheath through this area is usually sufficient.³ Removal of a portion of the tendon sheath may be necessary to achieve free tendon movement. Lateral incision of the tendon sheath as proposed by Bunnell is more likely to result in trauma to the proper digital nerves and probably is not required.

Summary

1. Non-suppurative tenosynovitis without "triggering" can be an enigmatic diagnostic problem.
2. Simple methods for the diagnosis of this condition are discussed.
3. Treatment with corticosteroids locally by injection is indicated as a diagnostic step and provides permanent relief in many instances. Surgery should be resorted to, only if conservative treatment is unsuccessful.
4. The etiology of non-suppurative tenosynovitis is seldom due to a single acute injury but may be secondary to repeated minor unrecognized trauma or general metabolic disturbances.
5. The physician must properly advise patients or employers when the patient returns to work in a job that can contribute to the aggravation of this condition.

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Myxedema Complicated by Pericardial Tamponade

STANLEY SPITZER, M.D.
ALBERTO ADAM, M.D.
DANIEL MASON, M.D.
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The cardiovascular system is affected in a variety of ways in the myxedematous patient. Pathologic studies have revealed among other things, ventricular dilatation, hypertrophy and pericardial effusion. The incidence and clinical significance of pericardial effusion in myxedema is difficult to determine.¹ The importance of it is illustrated by the following case:

A sixty-five year old white female was admitted to Hahnemann Medical College and Hospital with a seven-month history of generalized edema. The patient had a past history of hypertension. There were no cardio-respiratory symptoms on admission. Physical examination revealed a deep hoarse voice, dry skin, blood pressure 170/120, pulse 60, respiration 12. The lungs were clear and heart tones were distant. No murmur or gallop was heard. The abdomen revealed modest hepatomegaly. There was ++++ pretibial edema. I-131 uptake was 2.7% in two hours, 2% in twenty-four hours. Serum cholesterol was 228 mgm.%. There was an abnormal glucose tolerance test. Blood CBC, BUN, serum electrolytes, alkaline phosphatase, serum protein electrophoresis, SGOT, SGPT were all within normal limits. Chest x-ray on admission is shown. (Figure 1) The initial portion of the patient's hospital course was involved in diagnostic studies which revealed primary hypothyroidism.

On the eleventh hospital day, desiccated thyroid was instituted, 15 mgm. daily. This was increased on the twenty-first hospital day to 30 mgm. daily. During this time, there was very little patient response with regard to pulse rate, weight or other clinical signs of thyroid function. On the twenty-fourth hospital day, the dessicated thyroid was increased to 45 mgm. The morning of the twenty-sixth hospital day, the patient complained of marked dyspnea and orthopnea. These symptoms became more pronounced through the day. That evening, the patient was digitalized and



Figure 1: Chest x-ray on admission.

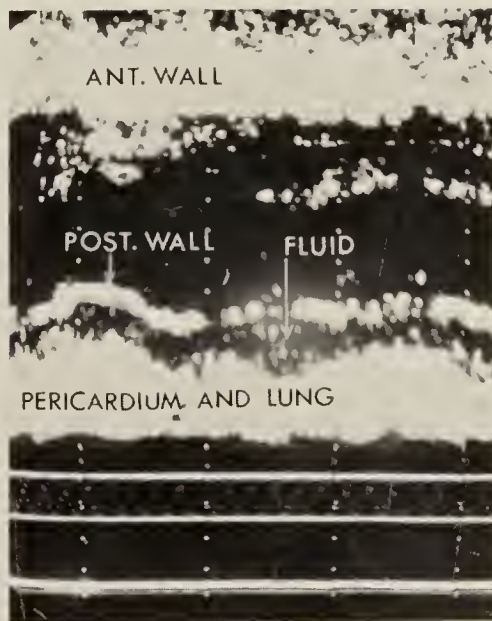


Figure 2: Echocardiogram with significant pericardial effusion between the posterior wall of the heart and the pericardium and lung.

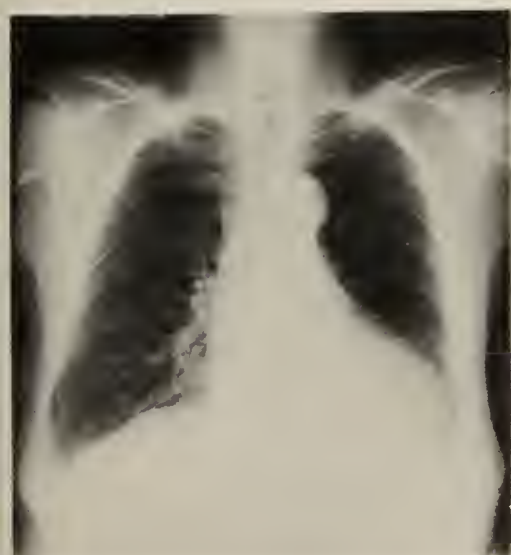


Figure 3a: Chest x-ray taken immediately after pericardiocentesis.

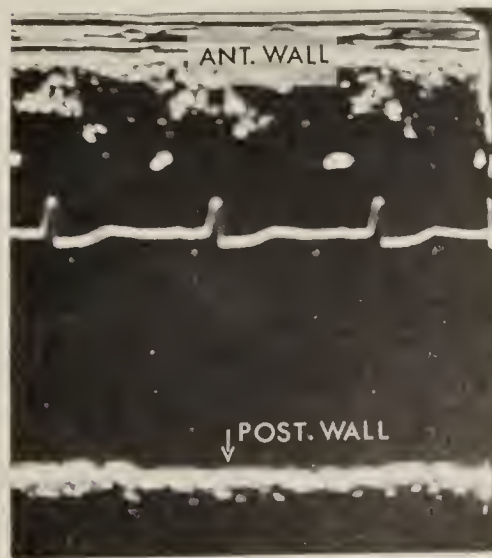


Figure 3b: Echocardiogram immediately after pericardiocentesis no longer reveals the pericardial effusion.

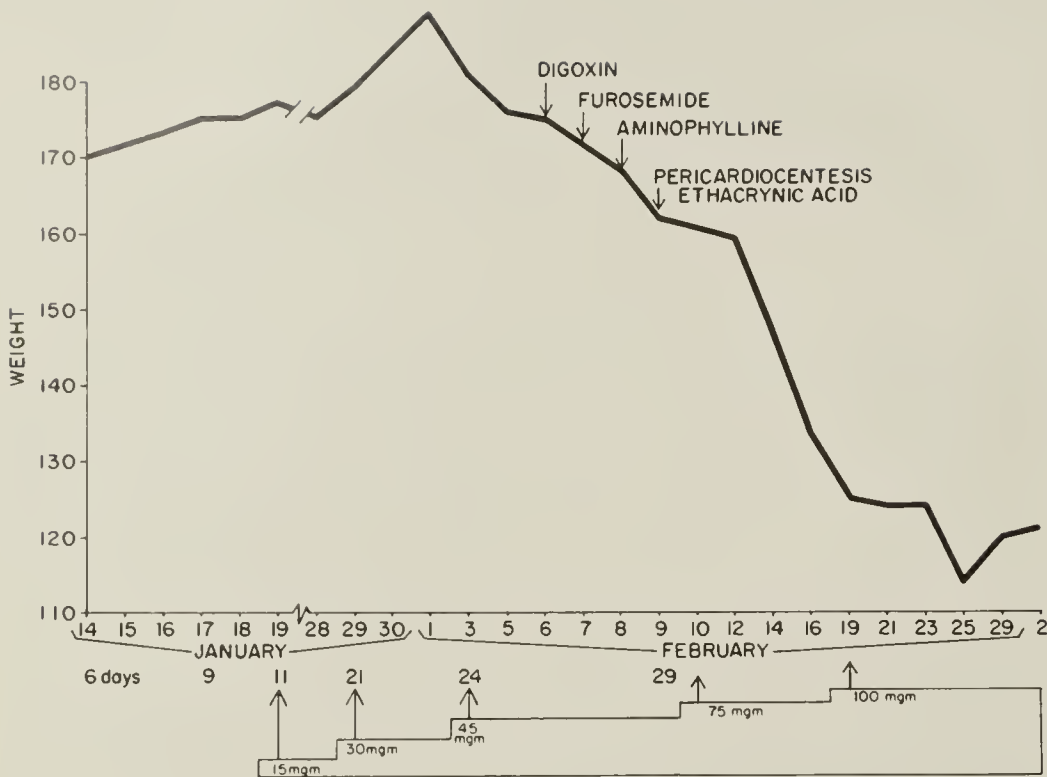


Figure 4: Body weight as index of patient response to therapy.

hydrochlorothiazide was added. There was minimal improvement over the next twenty-four hours. Aminophyllin intravenously as well as furosemide failed to produce significant improvement.

During the afternoon of the twenty-ninth hospital day, the patient became hypotensive. Inspection revealed marked neck vein distention, with increase in distention in inspiration. A paradoxical pulse was present, and the heart tones were distant. Pericardial effusion with tamponade was diagnosed. At that time, ultrasound scan (Figure 2) confirmed the clinical impression. Pericardiocentesis was performed with the removal of 1,400 ccs. of clear fluid (Figure 3). There was remarkable improvement during the next twelve hours. Dessicated thyroid was increased to 75 mgm. daily. The patient continued to improve and was discharged on the fifty-second hospital day asymptomatic. (Figure 4)

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Discussion

A patient with myxedema, pericardial effusion and symptomatic tamponade is presented. The effusion was definitely diagnosed by ultrasound.⁸ The feasibility of using ultrasound in the diagnosis of pericardial effusion was first demonstrated by Edler.⁹ With its ability to detect interfaces between liquid and solid, ultrasound technique makes it possible to demonstrate pericardial fluid both anterior and posterior to the heart. Numerous papers have appeared attesting to the efficiency of the ultrasound technique in pericardial effusion.^{10,11}

Pericardial effusion can occur in myxedema, but the frequency with which it occurs is unknown. The fluid accumulation is slow and usually well-tolerated, tamponade is an uncommon occurrence.^{2,3,4,5} In the case discussed, tamponade became evident by the usual clinical signs. The marked improvement after pericardiocentesis attests to the hemodynamic significance of the effusion. Martin and Spathis³ in discussing what they felt was the first case of pericardial tamponade in myxedema, considered bleeding to be a factor in the formation of pericardial fluid. The fluid they obtained was dark and had a high bilirubin content in contrast to the fluid obtained in our case (Table 1).

In Ivy's case⁶ of myxedema precoma with pericardial effusion, 2,100 ccs. of straw-colored fluid was removed by pericardiocentesis. The fluid analysis by Kern et al⁷ was very similar to ours. The etiology of the effusion is unknown; it appears to be a simple transudate. The frequency of pericardial effusion in hypothyroidism is unknown, but it would appear to be more common than clinically suspected. Tamponade is rare. It is our feeling that the pericardial effusion in myxedema is usually not hemodynamically significant, and treatment of the underlying endocrine imbalance is all that is needed. Only a very rare case of tamponade requires pericardiocentesis. Whether, as Kern states, "pericardial effusion is a constant and early finding and the major factor in the cardiac findings in myxedema" remains to be proven.⁷ Ultrasound scan may provide the tool to prove this.

Synopsis—Abstract

A case of myxedema with massive pericardial effusion and tamponade is presented. The effusion was conclusively diagnosed by reflected ultrasound. The fluid had the characteristics of a transudate. Its site of origin is unknown. Pericardial effusion in myxedema is rarely hemodynamically significant.

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Neurological Manifestations of Hypothyroidism

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and

JOSEPH B. BITTENBENDER, M.D.

Harrisburg

Hypothyroidism has long been known to be associated with neurological manifestations, mental retardation, coma, and various psychoses. While many cases of myopathy associated with hyperthyroidism are on record, cases of myopathy associated with hypothyroidism are infrequent. For this reason and because of the unusual response to thyroxin, the following case is reported.

A 62-year-old, white female was admitted to the Harrisburg Polyclinic Hospital on January 8, 1965 with the chief complaint of progressive weakness of her lower extremities. Twenty years prior to admission she had been troubled with frequent episodes of amenorrhea and basal metabolism tests supported a diagnosis of hypothyroidism. She was placed on desiccated thyroid and well controlled on three grains a day. She was in relatively good health until January, 1964, when she suffered an acute anteroseptal wall myocardial infarction

well substantiated electrocardiographically and then thyroid medication was discontinued. During hospitalization for this illness mild diabetes was discovered. This was managed with Orinase 0.5 gms. twice daily but she was put on a reducing diet and a diet pill.

Following discharge she began to lose weight but because the diet pills made food distasteful to her she discontinued them. Nevertheless she continued to lose weight and lost a total of fifty pounds in the following year. She became so anorexic that she was admitted for investigation in November, 1964, but aside from generalized diverticulosis of the colon (diagnosed by Barium enema) and a small duodenal polyp (diagnosed by upper G. I. series) no explanation of her weight loss was found. A PBI done at that time was 3.5 mcgs. (hypothyroid range for this laboratory).

Six months prior to her present admission she developed progressive weakness of her lower extremities which did not

vary in uniformity during the day. By the time of admission this had reached the point that she required a walker for ambulation, and needed assistance in sitting up in bed. In addition she had developed increasing weakness in both upper extremities during the two months prior to admission.

For at least eight months prior to admission she had numbness and tingling in her hands and feet and she had noted a tight sensation about the lower portion of her thorax bilaterally. She also had mild intermittent ringing in both ears for the past year. She denied any other neurologic symptomatology.

Review of Systems

Review of systems revealed that in addition to the above symptoms she had become progressively lethargic over the year prior to admission and developed cold intolerance and constipation requiring enemas. Additional past history disclosed that she had an appendectomy and tonsillectomy as a child and fractured her left tibia during her teens.

General Physical Examination

A general physical examination revealed a well-developed, white female who was rather jocular and did not appear malnourished or in any acute distress. Pulse, respirations and temperature were within normal limits and the blood pressure was 120 mm systolic and 80 mm diastolic. Her skin was dry, cool, pasty, and thickened. There was puffiness of the face and eyelids. There was a well healed right lower quadrant incision. Examination of the nose, throat, heart, lungs and abdomen was otherwise within normal limits.

Neurological Examination

On neurological examination there was mild weakness of the shoulder girdle musculature in the upper extremities more on the right than the left, slight bilateral triceps weakness, and slight weakness of the intrinsic hand muscles more on the right. Pelvic girdle musculature was reduced 70 to 90 per cent in strength bilaterally. Straight leg raising could barely be accomplished against gravity on the right.

There was 40 to 60 per cent loss of power in the quadriceps and hamstring muscles bilaterally. Dorsiflexion and plantarflexion of the right foot and toes were quite weak. Deep tendon reflexes

"...a diagnosis of hypothyroidism

and myopathy and neuropathy

was warranted on the basis of

the electromyographical findings..."

were barely obtainable in the upper extremities and unobtainable in the lower. No pathological reflexes were noted. There was doughiness and some atrophy of the pelvic and shoulder girdle muscles bilaterally and to a lesser degree the calves. No fasciculations were noted.

On sensory examination there was glove and stocking hypesthesia and hypalgesia bilaterally progressively worse in the distal portions of each extremity. There was almost no vibratory sensation below the knees and minimal loss in the fingers bilaterally. Position sense was intact on all four extremities. Examination of the cranial nerves including funduscopic and visual fields was unremarkable.

There was a pelvic tilt on walking but no frank ataxia. Gait was accomplished with support and was steppage in character. The Romberg was slightly positive. Rapid alternating movements were performed in a clumsy manner but frank dysmetria was not observed.

Significant laboratory findings were: fasting blood sugars between 97 and 225 mgm%, a total cholesterol of 316 mgm%, a BMR of -20% and a PBI of 12.7 mcgs% (thought to be due to previous radio contrast studies) which was not significantly altered by TSH stimulation. A 24-hour I^{131} uptake of 2.5% was also observed; and this, too, did not change significantly after TSH stimulation.

Sedimentation rate varied between 19 and 30 mm. per hour with a normal of 14 to 21 mm/hour. BUN's, CBC's, urinalysis, electrolytes, serum proteins, a 24-hour creatinine and prothrombin times were normal.

An EKG revealed non-specific ST and T wave changes compatible with digitalis effects and evidence of old anterior wall myocardial infarction. A chest X-ray of January 9, 1965 revealed the presence of a hazy, uniform increase in density throughout the anterior superior mediastinum which was not well demonstrated on oblique views. Repeat chest X-rays failed to show any increase in the size of this density during her three months of hospitalization. This was felt to represent a substernal thyroid.

Electromyography performed on January 26, 1965 revealed numerous short duration, low amplitude, polyphasic action potentials resembling myopathic units in the shoulder and pelvic girdle muscles bilaterally. In addition there was diffuse denervation (fibrillation potentials) in the muscles of both lower and the right upper extremities. The motor nerve conduction velocity of the right median, peroneal, and tibial nerve were slow, compatible with a peripheral polyneuropathy.

In view of these findings the patient was placed on synthroid 0.025 gm in addition to Orinase 0.5 gms b.i.d., Digitoxin 0.1 mgm o.d., Esidrex 25 mgm o.d., and multivitamins which she

had been on since her previous admission. Physiotherapy was also instituted. There was daily improvement in walking, general muscle strength and libido. Her weight remained stable. By the time of discharge, two months after instituting therapy she could walk with a cane. A BMR at that time was +5%.

A one-month followup revealed the following. Her libido and general sense of well-being had further improved. There was only minimal weakness on flexion and extension of the left leg at the hip. She could elevate her right leg to 90 degrees with ease but there was still 20 to 30 per cent loss of power in the right pelvic girdle musculature. There was still 20 to 30 per cent loss of extension of the right leg at the knee. Power of extension of both feet and toes was unimproved. Good biceps and triceps reflexes were obtainable bilaterally, while brochioradialis reflexes were still diminished. A good left knee jerk and weak left ankle jerk were now obtainable. No reflexes were obtained in the right lower extremity. Right quadriceps and gluteal muscles remained slightly atrophic, but the left were increased in mass. No fasciculations were noted. Hypesthesia and hypalgesia was noted in the right hand, left fingers and right and left feet but definitely less than on the initial examination. Vibratory sensation had returned to both lower extremities but was diminished below the hips to a greater degree on the left. Gait (without support) was steppage but remarkably improved. Romberg was still slightly positive. There was no dyskinesia or dysmetria. The rest of the examination was within normal limits.

A repeat electromyographic study revealed increased amplitude of all potentials and only a few polyphasic action potentials in the muscles examined. Conduction velocities of the peroneal and tibial nerves were improved.

It was felt that a diagnosis of hypothyroidism and myopathy and neuropathy was warranted on the basis of the electromyographical findings and the unusual improvement following thyroid hormone therapy in this case.

Review of the Literature

The first muscular abnormalities to be described in hypothyroidism were the delayed contraction and relaxation of the

voluntary muscles associated with muscular hypertrophy and labeled Hoffman's syndrome after the man who first described it (1896). He noted improvement of this disturbance after thyroid hormone. Since then symptoms of this type have been described in a number of publications. More recently Sisson et al. (1962) reported myotonia of the orbicularis oculi with myxedema. This patient also exhibited myotonia of the upper extremities. Electromyographic studies revealed asynchronous action potentials of declining amplitude following voluntary motion in contrast to the synchronous action potentials of declining amplitude noted in myotonia congenita. No myopathic units were noted. There was a remarkable response to thyroid hormone in this case. Lewitus and Bornstein (1962) reported seven cases of myotonia out of a series of 102 cases of documented myxedema. There was no associated muscular dystrophy. While electromyographic studies were not recorded, prompt response was noted on thyroid hormone.

According to Lambert (1951) the myotonia described in these cases is distinctly different from the delayed contraction and relaxation of the tendon reflexes seen in hypothyroidism (called pseudomyotonia). He found that 77 per cent of patients with hypothyroidism exhibited this pseudomyotonia or alteration in tendon reflexes which disappeared after thyroid hormone therapy.

Isolated cases of muscular dystrophy with hypothyroidism have been reported but very few have been documented with electromyographic studies and/or muscle biopsy. Astrom, Kugelberg and Muller (1961) reported on eight cases of hypothyroidism with myopathy who had just such documentation. These cases exhibited marked similarity to the one reported here. The similarities are: (1) The weakness was most pronounced in the proximal muscle groups especially of the lower extremities. (2) No evidence of myotonia was noted. (3) EMG studies of the quadriceps muscles revealed polyphasic action potentials of low amplitude and short duration. (4) While spontaneous fibrillation potentials were observed in one case there was no insertion activity or delayed asynchronous action potentials in the others.

Muscle biopsy disclosed signs of acute degeneration in all cases. Muscle fibers varied in size, many contained increased

numbers of sarcolemma nuclei and displayed hyalinization or granular and vacuolar degeneration. Some were completely replaced by connective tissue and fat. In one case that died in myxedema coma, mucoid degeneration of segments of some of the muscle fibers was noted. These findings had been previously reported by Berkheiser (1955). This was a foamy PAS positive material and was found in cardiac muscle as well.

Unlike the case reported here these cases did not respond to thyroid hormone therapy. Nor did clinical, electromyographic or biopsy findings indicate peripheral nerve involvement.

A well documented case quite typical of Erb's limb girdle muscular dystrophy associated with hypothyroidism was reported by Comings (1962). Electromyography revealed large polyphasic motor units and fibrillation as well as multiphasic low amplitude potentials on voluntary effort. Muscle biopsy disclosed

*“...myopathy
associated with
hypothyroidism
is the first to respond
to thyroid hormone.”*

vacuolar, hyaline and waxy degeneration of individual scattered muscle fibers. There was no family history recorded. Again no improvement on thyroid hormone was noted.

The electromyographic findings in myxedema have been summarized by Waldenstein et. al. (1958). They performed EMG's on patients with frank myxedema and found the following four different abnormalities: polyphasic action potentials; continued low voltage short duration irregular after discharges (following voluntary motion); hyperirritability on insertion or movement of

the electrode; repetitive discharges after reflex motion (on tapping the tendon). These findings were rarely found in hyperthyroidism. They usually disappeared after treatment. The action potentials found in our case and other cases of hypothyroid myopathy are of low amplitude, short duration, and polyphasic. These are similar to those found in muscular dystrophy.

While paresthesias and less commonly peripheral hypesthesia and hypalgesia have been described in cases of myxedema it has been doubted that true myxedematous neuropathy exists according to Sanders (1962). On the other hand, Nickel et. al. (1961) described edematous infiltration of the endoneurium and perineurium as well as degenerative changes in the myeloid sheaths and axis cylinders in cases of hypothyroidism. The clinical and EMG improvement on thyroid therapy in this case supports a diagnosis of hypothyroid neuropathy. However, diabetes mellitus cannot be excluded as the cause. On the other hand the frequency of paresthesias in hypothyroidism may be due to the carpal tunnel syndrome produced by myxedematous tissue beneath the transverse carpal ligament. Murray and Simpson (1958) found twenty-six patients with paresthesias of the hands had electromyographic findings compatible with a carpal tunnel syndrome. Many of these cases improve after thyroid therapy (Purnell et. al., 1961). This would not explain paresthesias in the lower extremities which are frequently reported.

Blepharoptosis has also been noted frequently in myxedema (Lee et. al., 1960) and usually responds dramatically to thyroid hormone therapy. Neuromuscular dysfunction of the levator palpebrae superioris muscle or Muller's palpebral muscles was proposed to explain this.

After reviewing the literature, then, two conclusions may be drawn. This case of myopathy associated with hypothyroidism is the first to respond to thyroid hormone. Furthermore, since the associated neuropathy was improved after thyroid hormone, this case provides additional support for the existence of hypothyroid neuropathy.

Discussion

Several questions are provoked by the above discussion. What is the cause of the

myopathy in hypothyroidism? Is the myopathy truly related to hypothyroidism or merely fortuitous? Does hypothyroidism aggravate a hereditary predisposition to muscular dystrophy? Is there some insufficiency of thyroid hormone in muscular dystrophy or some end organ unresponsiveness?

To answer the first of these questions, the cause of myopathy in hypothyroidism is still unknown. Several theories have been proposed, however. Thyroxin is known to increase the metabolic rate and oxygen consumption of all tissues including muscle. Muscle glycogen could be easily depleted in hyperthyroidism and might accumulate in hypothyroidism. There is, however, no objective evidence of this so far. Astron et al. did not report staining of their muscles for glycogen.

As a result of the rapid metabolic rate in hyperthyroidism, catabolism of muscle for energy may lead to muscular degeneration and atrophy. However, in hypothyroidism, this would not be the case. On the other hand, the rate of muscle anabolism could be decreased and degeneration might appear for this reason.

That thyroxin excess inhibits both the conversion of creatine to creatinine and the formation of phospho-creatine is well known. Since phospho-creatine is the principle source of muscle energy, it is not strange that experimental and clinical evidence shows that its deficiency may be responsible for hyperthyroid myopathy. (Thorn and Eder, 1946.) In hypothyroidism, however, phospho-creatine formation is not inhibited. It may be that excessive muscle cell accumulation of phospho-creatine in hypothyroidism is responsible for the associated myopathy.

It is also known that thyroxin stimulates loss of water and potassium from the cells. It may be possible that in hypothyroidism intracellular potassium rises to toxic levels damaging the muscle cells. This same event occurs in familial periodic paralysis in which vacuolar changes have been observed in the muscles. Serum and total body magnesium has been found to be high in hyperthyroidism and low in hypothyroidism (Rosselle, 1962). It is conceivable that thyroxin deficiency adversely affects the intracellular levels and function of critically placed magnesium ions. (Sanders, 1962.)

From evidence that curare blocks the

prolonged contraction and relaxation time of myxedematous rats, Ingold (1956) postulated that thyroxin acts at or proximal to the neuromuscular junction by regulating the number of muscle cells discharged with each nerve impulse. Increased thyroxin inhibits the number of muscle cells discharged while decreased thyroxin increases the number discharged. This is the best explanation yet advanced for the pseudomyotonia and myotonia in hypothyroidism. Furthermore, exhaustion atrophy could result from the increased discharge in hypothyroidism.

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As already mentioned above, muscle biopsies in isolated cases of hypothyroid myopathy have shown the presence of a mucoid foamy infiltrate in some of the degenerated muscle fibers. Submicroscopic amounts of this same substance could be responsible for the myopathy in the other cases reported.

The documented cases reported by Astron et al. (1961) would seem to answer the second question with an emphatic no. The case reported in this paper in which the myopathy responded to thyroid is further evidence that hypothyroid myopathy is a distinct entity.

In our search of the literature we failed to find any case reported of hypothyroid myopathy in which there was a hereditary background. Thus the third question must be answered no at this point. However, there may be cases that were not reported because of such a background.

The last question cannot be answered with certainty at this time. Myotonia congenita and myotonia dystrophica have occasionally been associated with myxedema in their course. The myopathy has not responded to thyroid, however.

Myotonia dystrophica involves the endocrine system but more often the testicles and parathyroids. A low metabolic rate has been frequently reported but is believed to be due to the reduced muscle mass and diminished movement and muscular excitation because of the disability.

Summary

- 1) A case of hypothyroidism associated with myopathy and neuropathy has been reported.
- 2) There was both clinical and electromyographic improvement of the myopathy and neuropathy on thyroid hormone.
- 3) Hypothyroid myopathy is a distinct entity.
- 4) The pathogenesis of the myopathy is still unknown.

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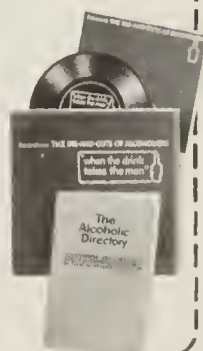
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Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

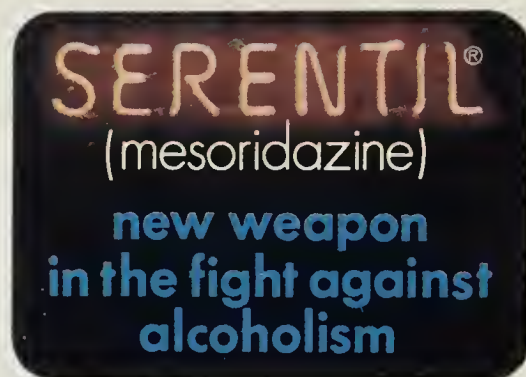
Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least 1/2 hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few



(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible.

There is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arrest, has been noted.

Extrapyramidal Symptoms: Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, akinesia—some of which on rare occasions have persisted for several months or years especially in patients of advanced age with brain damage.

Endocrine Disturbances: Menstrual irregularities, altered libido, gynecomastia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxical reaction have been reported. These include excitement, bizarre dreams, aggravation of psychoses and toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long-term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclera and cornea. Opacities of the anterior lens and cornea described as irregular or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dosage of Serentil (mesoridazine), as in most medications, should be adjusted to the needs of the individual. The lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to a maintenance level.

Alcoholism: For most patients the usual starting dose is 25 mg. b.i.d. The usual optimum total daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless of severity, a starting dose of 50 mg. t.i.d. is recommended. The usual optimum total daily dose range is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: For most patients a starting dose of 25 mg. t.i.d. is recommended. The usual optimum total daily dose range is 75-300 mg. per day.

Psychoneurotic Manifestations: For most patients the usual starting dose is 10 mg. t.i.d. The usual optimum total daily dose range is 30-150 mg. per day.

Injectable Form: In those situations in which an intramuscular form of medication is indicated Serentil (mesoridazine) Injectable is available. For most patients a starting dose of 25 mg. is recommended. The dose may be repeated in 30 to 60 minutes, if necessary. The usual optimum total daily dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg. and 100 mg. mesoridazine (as the besylate). Bottles of 100.

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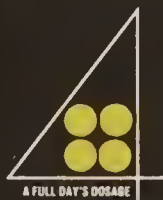
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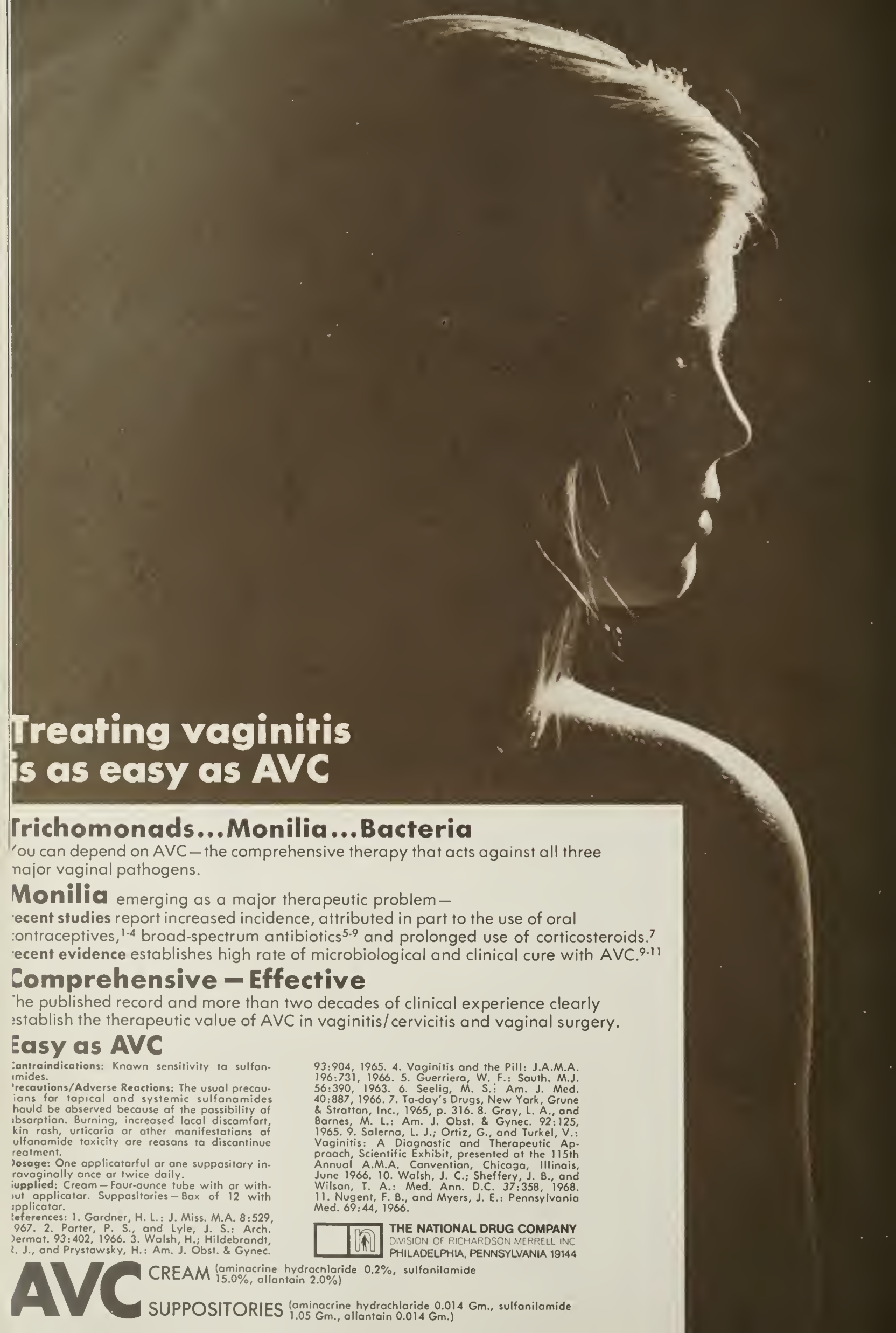
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Cardiac Resuscitation in 512 Hospitalized Patients

PHILIP VOLASTRO, M.D.
PETER SIGMANN, M.D.
WILBUR W. OAKS, M.D.
Philadelphia

Since the initial major report, nine years ago, of the application of closed chest cardiac massage,¹ an aggressive approach to cardiac resuscitation has unquestionably proven itself, particularly in the treatment of cardiac arrest following acute myocardial infarction. Three phases of resuscitation have become prominent in recent studies: 1. resuscitation at home or en route to the hospital by mobile resuscitation units, 2. resuscitation in the hospital, 3. resuscitation in coronary care units.

The mobile unit of the Royal Victoria Hospital answered 312 calls during a fifteen-month period and resuscitated 10/10 patients successfully en route to the hospital.² 155 patients of the 312 had confirmed infarctions when hospitalized. Several reports of in-hospital resuscitative efforts have realized a 12-15

per cent success rate.^{3,4} Variation in success has been significantly influenced by patient selection and by the inclusion or exclusion of surgical and anesthetic cardiac arrests which carry an excellent recovery rate (over 50 per cent).^{5,6} Success in acute myocardial infarctions alone was in the 30 per cent range when uncomplicated by pulmonary edema, shock, or prolonged arrhythmia.^{7,8} *Coronary care units* have been successful in the prevention of cardiac arrests by the early

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detection and treatment of arrhythmias and congestive heart failure. In addition, they report a survival of 38 per cent in cardiac arrests.⁹ However, a significant number of patients with myocardial infarction are not placed in coronary care units either because of insufficient beds or inaccurate diagnosis.

Hahnemann Hospital is a 544-bed hospital with patient care and evaluation spread out over seventeen floors. In order to improve resuscitative efforts in cardiac arrests, a cardiac resuscitation system was organized.¹⁰ This report describes the results of an aggressive approach to cardiac resuscitation in 512 cases occurring in-hospital over a four-year period.

Material and Methods

Code 99 became operative in December, 1964, after a year of research and planning. A team, specially trained, consisting of three medical and one anesthesiology residents and one nurse, is available on radiopage signal for Code 99 calls at any time of the day or night. The second and third medical members of the team are replaced every three months to provide progressive training for a number of experienced residents and adequate coverage on nights and weekends. With a priority telephone line, carefully rehearsed switchboard procedures, and telephonic elevator control; the time between the emergency signal and the arrival of the first team member is an average of thirty seconds, and two to three minutes for the presence of a complete team and the equipment. A commercially available resuscitation vehicle, the MAXCART*, as developed and described by Nobel and Templeton, has been used to aid in resuscitation.⁴ This cart contains all necessary tools, drugs, and electronic equipment. The patient is placed on the cart and external cardiac massage is taken over by a pressure powered apparatus (CARDIOPULSE*). The cart is equipped with an oxygen supply and a storage battery and is fully functional even in transit.

The established team approach to therapy in a cardiac arrest includes: (1) closed chest cardiac massage and oral ventilation with oxygen; (2) continued massage by machine after the patient is placed on the cart; (3) immediate diagnosis of the cardiac rhythm and defibrillation if indicated; (4) immediate

* Corbin-Farnsworth, Inc., Palo-Alto, California.

TABLE 1
CODE 99 SUMMARY
DIAGNOSIS OF UNDERLYING DISEASE
IN 512 PATIENTS WITH CARDIAC ARREST

Major Diagnosis	Total Patients	Class 1	Class 2	Class 3	Class 4
Acute Myocardial Infarction with or without complications	182	105—45%	34—19%	15—8%	28—15%
Arteriosclerosis without infarct	60	27—44%	10—17%	7—12%	16—27%
Rheumatic & Congenital heart disease including post op	65	40—62%	12—18%	7—11%	6—9%
Pulmonary Disease Pneumonia, Aspiration, Chronic Obst.					
lung Disease	57	35—62%	15—26%	4—7%	3—5%
Uremia	33	21—64%	8—24%	2—6%	2—6%
CNS Disease or Trauma	24	13—54%	6—25%	3—12%	2—9%
Pulmonary Embolus	15	11—73%	1—7%	1—7%	2—13%
Severe Hemorrhage	12	7	3	2	
Intoxication	9	7	1	1	
Pulmonary Edema Unknown etiology	7	3	3		1
Metabolic Acidosis	6	3	3		
Acute Abdomen (ileus, obstr., perf.)	7	3	4		
Dissecting Aneurysm	6	4	2		
Septic Shock	3	2	1		
Status asthmaticus	3	2		1	
Fat Embolism	1		1		
Myocardopathy	5	1	1	1	2
Perforation of Heart	1	1			
Idiopathic Heart Block	1				1
Dye Reaction	1				1
Delivery	1		1		
Vasculitis	2	1		1	
Unknown	11	7	3	1	
TOTAL	512	293—57½%	109—21%	46—9%	64—12½%

administration of hypertonic sodium bicarbonate at a rate of 50 mEq every three minutes by venous cutdown or by central venous catheter.

Considerable drug therapy is used for the specific treatment of underlying conditions.

Special procedures often become necessary: placement of a transvenous pace-maker electrode in complete heart block; pericardiocentesis in tamponade; etc. In addition, the cardiac arrest system has

been successfully used to maintain renal perfusion and oxygenation in possible donors for kidney transplantation.

An analysis is presented of "CODE 99" calls between December 4, 1964, and September 30, 1968 involving 512 patients. The patients included in this report had cessation of cardiac activity with absence of palpable carotid and femoral pulses or ECG evidence of asystole or ventricular fibrillation. Cardiac arrests from anesthesia or during

surgery were excluded from our statistics.

Results

The final results of our approach to the problem of cardiac arrest are listed in Table 1 according to the following classification:

- CLASS 1: Immediate failure—death within one hour
- CLASS 2: Immediate success—patients restored to spontaneous cardiac activity, but died within twenty-four hours or never regained consciousness
- CLASS 3: Full recovery of consciousness—patients survived over twenty-four hours
- CLASS 4: Patients discharged from the hospital in prearrest neurologic status or remained within the hospital after four weeks without sequelae of cardiac arrest.

The overall results are listed in Table 1. Whereas, the efforts to resuscitate these patients resulted in immediate failure in 57.5 per cent (Class 1), and in shortlived or incomplete success in 21 per cent (Class 2), 9 per cent of the patients survived over twenty-four hours with

TABLE 2
CODE 99 SUMMARY
RESULTS OF RESUSCITATION IN CARDIAC ARREST
DUE TO MYOCARDIAL INFARCTION

Myocardial Infarct	Total Patients	Class 1	Class 2	Class 3	Class 4
A. Clinically diagnosed with stable vital signs, no heart failure, sudden cardiac arrest: or accident ward admission following cardiac arrest, pupils not dilated	90	47—52%	14—16%	4—4%	25—28%
B. With pre-existing shock and/or pulmonary edema and/or resistant arrhythmia	66	42—63%	14—21%	7—11%	3—5%
C. With complicating, not directly related illness or as complication thereof	26	16—62%	6—23%	4—15%	

TABLE 3

	Total		Class 1		Class 2		Class 3		Class 4	
	Patients	%	No.	%	No.	%	No.	%	No.	%
<i>Sex</i>										
Male	308	61%	189	61%	58	19%	26	8%	35	12%
Female	201	39%	101	50%	51	25%	20	10%	29	15%
Not Recorded	3	—	3	—	—	—	—	—	—	—
<i>Age</i>										
Below 40	71	14%	38	54%	21	30%	6	8%	6	8%
40-49	85	15%	50	59%	16	19%	6	7%	13	15%
50-59	112	22%	67	60%	19	17%	11	10%	15	13%
60-69	134	27%	83	62%	21	16%	12	9%	18	13%
70-79	82	16%	40	49%	25	30%	7	9%	10	12%
Above 80	13	3%	5	39%	4	31%	2	15%	2	15%
Unknown	15	3%	10	67%	3	20%	2	13%	—	—
<i>Rhythm</i>										
Ventric. Fibrillation	159	31%	85	53%	28	18%	14	9%	32	20%
Ventric. Tachycardia	20	4%	6	30%	7	35%	2	10%	5	25%
Asystole	152	30%	94	62%	34	22%	9	6%	15	10%
Idioventricular	106	21%	68	64%	22	21%	12	11%	4	4%
Other	59	11%	34	58%	13	22%	6	10%	6	10%
Unknown	16	3%	6	37%	5	31%	3	19%	2	13%
<i>Location</i>										
Medical Wards	64	12%	37	58%	17	27%	4	6%	6	9%
Other Wards	19	4%	12	63%	6	32%	—	—	1	5%
Private Floors	170	33%	107	63%	27	16%	14	8%	22	13%
Intensive Care	145	28%	85	59%	33	23%	18	12%	9	6%
Emergency Room	90	18%	42	47%	21	23%	7	8%	20	22%
Other Areas	24	5%	9	37%	6	25%	3	13%	6	25%
<i>Time</i>										
8 A.M.—5 P.M.	219	43%	119	55%	53	24%	18	8%	29	13%
5 P.M.—M.N.	157	31%	91	58%	35	22%	12	8%	19	12%
M.N.—8 A.M.	113	22%	68	60%	19	17%	12	11%	14	12%
Not Recorded	23	5%	15	65%	2	9%	4	17%	2	9%
	512		293	57½%	109	21%	46	9%	64	12½%

recovery of consciousness (Class 3), and 12.5 per cent were definite survivors as defined in Class 4. Though the most promising results were obtained in patients arresting because of primary cardiac disease, fourteen patients with other diseases were discharged from the hospital, seventeen others attaining Class 3 status.

In Table 2, the results are detailed in 182 cases of cardiac arrest following *myocardial infarction*: When the cardiac arrest occurred as the first complication in an otherwise stable post-infarction period (Class 4) the survival rate was 28 per cent. In hypotension, heart failure, or arrhythmias resistant to therapy only three of sixty-six patients could be permanently resuscitated. An equally poor result was obtained when myocardial infarction was complicated by severe, unrelated illnesses.

Rhythm: An analysis of the results in the

various presenting electrical rhythms (Table 3) shows a better than average success in ventricular fibrillation (20 per cent, Class 4) and ventricular tachycardia (25 per cent, Class 4), and also the possibility of success when asystole is evident on the ECG—survival rate of 10 per cent.

Time and Place: (Table 3) Results were clearly better when the arrest was unexpected, such as in the E.R., various extraordinary areas, e.g. x-ray, private floors. Patients in ICU did poorly despite excellent monitoring devices and resuscitation facilities. This result, in the absence of a coronary care unit, was undoubtedly due to the fact that only patients with complicated myocardial infarctions and other complicated illnesses were admitted to the unit. Also in many cases, they had already been treated with a maximum cardiac regimen

prior to the arrest. Ward patients also fared poorly because of the high incidence of complicated illnesses.

The time of cardiac arrest did not influence the outcome of resuscitation. Diligent preparedness allowed for equally good results after midnight as during the day.

Age: (Table 3) The age of the patients bore no relationship to the ultimate results. Poor results below the age of forty may be related to attempted cardiac resuscitation in young persons despite their being poor Code 99 candidates.

Repeated cardiac arrests: Nine patients had recurrent cardiac arrests between periods of relative cardiovascular stability. All of these had myocardial infarction or arteriosclerotic heart disease. Of this group, four recovered completely and were discharged. One patient, a 51-year-old white male, during

TABLE 4 FOLLOW UP OF 46 CASES						
	Known Follow Up	Total Cases	Living	Lived 1 Yr.	Lived 6-12 Mos.	Lived 0-6 Mos.
1965	9	(14)	5	2	1	1
1966	13	(19)	10	1	1	1
1967	14	(18)	11	1	—	2
1968 (Jan-Sept)	10	(13)	5	—	1	4
45 Months	46	(64)	31	4	3	8

TABLE 5									
CARDIAC ARRESTS									
1ST. 18 MOS. VS. LAST 18 MOS.									
		Class 1		Class 2		Class 3		Class 4	
<i>January 1, 1965-June 30, 1966</i>									
Acute Myocardial									
Infarction	64	39	61%	9	14%	7	11%	9	14%
Overall	150	83	55%	30	20%	15	10%	22	15%
<i>April 1, 1967-September 30, 1968</i>									
Acute Myocardial									
Infarction	67	36	54%	12	18%	5	7%	14	21%
Overall	220	129	59%	45	20%	17	8%	29	13%

the course of a myocardial infarction had thirty episodes of ventricular tachycardia and two episodes of ventricular fibrillation necessitating defibrillation and large doses of antiarrhythmic agents. He recovered completely and returned to his work, but died about one year later following another myocardial infarction.

Complications: Rib fractures occurred in about 6 per cent with closed chest cardiac massage, gastric dilatation in 3 per cent. Pneumothorax occurred in six patients, a flail chest in four, chest burns from electroshock in four. Vomiting before or during intubation was a significant limiting factor in many of the unsuccessful attempts.

Follow-Up: (Table 4) Information was obtained in forty-six of the sixty-four survivors. Of these, thirty-one were alive and active on September 30, 1968—as long as forty-five months after cardiac arrest.

Of the fifteen patients who died after discharge from the hospital, seven survived over six months. It is interesting that the percentage of early survivors remains approximately equal to the percentage of the last year's survivors. This indicates that the prognosis following successful cardiac resuscitation can be quite favorable. Of the patients lost to follow-up about 50 per cent were ward patients who discontinued attendance in our clinics. One of these patients—not

included in Table 4, was successfully resuscitated in January, 1965 and again in July, 1966. He was last seen doing reasonably well in June, 1967 but no recent information is available.

Progress: (Table 5) A comparison of the results of the first eighteen months versus the last eighteen months of this program reveals an increase from 14 per cent to 21 per cent Class 4 survival in patients with myocardial infarctions, complicated or uncomplicated. This is in spite of very little improvement in methods of treatment of arrhythmias and pump failure during this time. In addition, the overall results were essentially unchanged (15 per cent versus 13 per cent) despite the fact that a more liberal number of patients were considered resuscitation candidates recently (150 in 1965-66; 220 in 1967-68). The hospital census was unchanged during this time.

Discussion

No doubt, coronary care units are presently the optimum place to treat cardiac arrhythmias and cardiac arrest. However, because of the significant number of unexpected arrests and because of the number of patients with primarily noncardiac diseases having cardiac arrests, the need for a smoothly run hospital-wide resuscitation system is indicated. For example, of thirty-three uremic patients who suffered cardiac arrest two were in Class 4. One of these

was continued on a successful peritoneal dialysis program for eleven months before expiring; the other went on to have a renal transplant and has done remarkably well more than one year post cardiac arrest. Neither of these two would have been in a coronary care unit!

Our overall results and our results in patients with myocardial infarctions are comparable to those previously reported.^{3,4,6} Persistence in resuscitating patients with far advanced disease—cardiac and noncardiac—has not been without rewards. Though the statistics show only a 5-10 per cent yield, continued efforts will be made to improve upon this.

The most important factor for the success of a resuscitation program is a well trained team and communication system on twenty-four-hour alert. The comparison of our initial and recent results show only a moderate improvement in spite of an increase in experience and sophistication. This appears to indicate that we are close to the limits beyond which improvement cannot be expected without major technological advances.

Conclusion

Since it appears impossible to give all hospitalized patients the benefit of a coronary care unit, the use of a hospital-wide resuscitation system is life saving for a significant number of patients.

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Clinical Experience with Acetohexamide

An Oral Hypoglycemic, Anti-diabetic Agent

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Sixty-eight patients with clinically confirmed diabetes mellitus were treated with the oral hypoglycemic agent acetohexamide from four to twenty-four months. Fifty patients remained on therapy long enough for evaluation; eight patients represented primary drug failures; two developed side-effects (minor); five were terminated for lack of cooperation, and three ceased to need oral therapy as their control improved with weight reduction. Nineteen patients sustained excellent, seventeen good, twelve fair, and two poor control while receiving treatment with this sulfonylurea-type antidiabetic compound.

The discovery and development of effective, safe oral hypoglycemic agents for the treatment of diabetes mellitus has added a new parameter to the therapy of this condition.¹ The well-recognized inadequacies of many of the currently available hypoglycemic drugs has stimulated a continued search for a

long acting, uniformly responsive, non-toxic, economical agent. Preliminary reports on a sulfonylurea agent that seems to fulfill most of these requirements first appeared approximately seven years ago with a gradual increase in reports of successful subsequent acceptance since that time.²⁻⁷

Acetohexamide (N-(4-acetylbenzenesulfonyl)-N¹ cyclohexylurea) differs from other sulfonylurea agents in its chemical composition and the activity of its principal degradation products.⁸ The structure of acetohexamide includes an acetyl group in the para position on the phenyl ring and a cyclohexyl group on the urea moiety while eliminating an amino group from the phenyl ring.⁹ The primary metabolite of acetohexamide is hydroxyhexamide with the L (–) configuration being most prominent.⁸ This metabolite has a significant hypoglycemic action in experimental animals and man, with a similar status being reported for two lesser metabolites 4¹ trans-hydroxyacetohexamide and 4¹ trans-hydroxyhexamide. There seems to be a great difference in the estimated duration of action of acetohexamide with reports varying from 1.3⁸ to 24¹⁰ hours. This disparity in duration of action is also noted in dose response studies.¹⁰

Due to the reports that acetohexamide was superior in duration and effectiveness of activity to tolbutamide without any added risk of toxicity,^{3,4,11,12} we studied the effect of this agent in the control of a group of diabetic patients. This report summarizes the results obtained during the evaluation of sixty-eight diabetics, twenty-seven of whom have been followed for at least eighteen months.

Materials and Methods

Sixty-eight patients followed in the outpatient diabetic clinic of a municipal hospital received acetohexamide for varying periods of time. Twenty-nine were begun on therapy as inpatients and later transferred to the clinic, while thirty-nine received their initial therapy with this agent as outpatients. All subjects were drawn from an indigent population, that by circumstance, intelli-

Table II

Number of patients studied	68
Duration of time on medication	4–24 months
Sex—male	30
female	38
Age range (mean)	30–78 (54)
Number still on therapy	50
Number stopped	18
failure of drug	8
side effects	2
lack of patient cooperation	5
success of weight reduction	3
Duration of diabetes mellitus	2 months — 13 years

Table I

Classification of response according to fasting blood sugar concentration (all determinations by Technicon Auto-analyser).

Excellent	less than	110 mg%
Good	less than	130 mg%
Fair	less than	150 mg%
Poor	over	150 mg%

gence and social mores make adherence to any prescribed medical regimen a difficult procedure. All patients had definite substantiated diabetes mellitus and were free of other endocrinologic disease, as far as could be determined by clinical impression and basic laboratory evaluation of thyroid and adrenal function when indicated. No attempt was made to screen patients for other diseases and many had concomitant hypertensive

vascular disease, coronary artery disease and degenerative joint disease.

Patients with hepatic disease or significant gastrointestinal disease that might interfere with absorption or nutritional status were not accepted for study. Many subjects were obese but none were actively involved in weight reduction programs and most had failed to successfully reduce their weight upon prescription in the past. In as far as possible with with an outpatient population, dietary prescription and intake were maintained constant. Changes in antidiabetic therapy were instituted only as indicated by attempts to control the blood sugar concentration.

Thirty of the study group were males; thirty-eight females. Their ages ranged from thirty to seventy-eight years with a mean of fifty-four years. Their diabetes was of two months to thirteen years duration (mean 5.2 years) and all had had previous attempts at therapeutic regulation with diet, diet and oral agents, or diet and insulin.

Treatment with acetohexamide was instituted in all patients by beginning with the smallest effective dose and increasing the amount administered as indicated by therapeutic response. Those on diet had acetohexamide added in 250 mg increments; those on previous oral hypoglycemic therapy had acetohexamide replaced as follows: tolbutamide-250 mg of acetohexamide .per 1000 mg, chlorpropamide-250 mg of

acetohexamide per 125 mg. All patients were seen in clinic every two to four weeks with venous fasting blood sugar, random urinary sugar and acetone and weight measured on each visit.

Blood sugars were determined by the Discombe modification of the glucose oxidase method by the Technicon Auto-analyzer.¹³ Tests of hepatic and renal function were performed in the general chemistry laboratory by routine acceptable methods. Control of diabetic status was evaluated by the criteria outlined in table I. All but eight patients received their total dose of acetohexamide once a day.

Results

Of sixty-eight patients studied fifty remain on acetohexamide as their only form of therapy besides diet. This group has been maintained from four to twenty-four months on this oral hypoglycemic therapy. Eighteen patients have been lost from the study; eight due to drug failure (7 primary and 1 secondary or late); 2 due to side effects (1 complained of dry mouth, 1 developed a rash); 5 due to lack of cooperation and 3 due to successful weight reduction while on oral therapy (Table II). The change in weight of the group successfully treated varied from a gain of 7 to a loss of 25 lbs. (mean loss 8 lbs.). If the 3 patients who lost sufficient weight to have their oral therapy discontinued are eliminated from the analysis the mean weight loss

is 4.5 lbs. Of those patients maintaining successful control; 19 were considered excellent, 17 good, 12 fair and 2 poor. Fasting blood sugar reductions varied from 15 to 210 mg% with a mean of of 127 mg%. The success of acetohexamide treatment had a direct relationship to previous modes of therapy. Only two maintained on diet alone failed to respond to oral therapy and both had been poorly controlled on diet. Of those on other oral agents, who were converted to acetohexamide therapy, six who were rated as responding fair or poor to other agents, had similar responses to their new regimen, however, seven of this group responded sufficiently to be continued on acetohexamide although previous oral therapy had been less than adequate. Of the group of twelve receiving previous insulin therapy seven failed to respond again predominantly from the fair or poor insulin response group. Successful control with acetohexamide seemed to depend to some extent on required total daily dose; with those requiring under 1.0 gram per day attaining the better control (Table III). Similarly, but less significantly, the previous dose of other oral agents seemed to correlate with successful control on acetohexamide with previous lower dosage leading to the greatest chance of success (Table IV). Figure 1 depicts the changes in fasting blood sugar levels in twenty-three patients transferred from tolbutamide to acetohexamide therapy.

Two patients with coronary artery disease and anginal syndrome noted disappearance or marked diminution of chest pain as diabetic control improved on acetohexamide. Two patients who continued self imposed weight reduction and one who maintained more accurate dietary control when placed on acetohexamide were able to improve their status sufficiently to eliminate the need for any supplemental oral therapy. One patient who had been hospitalized with hyperosmotic non-ketotic coma with an admitting blood sugar of 900 mg% was subsequently maintained on 250 mg of acetohexamide twice a day.

Discussion

There can be no doubt about the beneficial effects of treatment of the diabetic state with acetohexamide. The overall success rate of fifty of sixty-eight pa-

Table III

Current status of control of those patients treated with Acetohexamide according to dose level.

Dymelor dose	<u>excellent</u>	<u>good</u>	<u>fair</u>	<u>poor</u>	<u>total</u>
250 mg	6	2			8
500 mg	8	6	2		16
750 mg	4	4	3		11
1,000 mg	1	4	4	1	10
1,250 mg			3	1	4
1,500 mg		1			1
	<u>19</u>	<u>17</u>	<u>12</u>	<u>2</u>	<u>50</u>

ients or over 73 per cent in this type of patient population is an exceptional result. The definite ability of acetohexamide to replace other oral agents with greater success and above all its apparent longer term activity as manifested by the smoother course of control are added benefits. Although there has been much controversy about which blood sugar values should be used to regulate therapy (fasting or postprandial) we were forced to use fasting levels due to the circumstances of our clinic and laboratory facilities. The apparent beneficial effects of acetohexamide using this criterion seem to indicate longer activity and less night-time hyperglycemia, a drawback of some oral agents.

Two patients developed side effects deemed serious enough to warrant termination of acetohexamide therapy; both had responded well clinically by that time. One patient developed a slightly pruritic maculopapular rash which in all probability was due to the oral hypoglycemic since it was his only treatment and it cleared when the agent was stopped. The second patient continually complained of dry mouth and lips without any clinical substantiation, however, upon stopping the medication and placing him back on small doses of insulin, all such complaints cleared. Although cases of skin rash,⁷ jaundice and abnormal hepatic function,^{3,5,7,11} gastrointestinal upset,^{5,7,13,14} and possibly one case of leukopenia¹⁵ have been reported, this drug is relatively free of toxic manifestations and side effects. Hypoglycemia^{14,15} occasionally progressing to coma^{16,17} has been described but may be due to underlying renal disease and uremia which contributes to this hypersensitivity.¹⁸ No specific routine laboratory studies of hepatic renal or hematopoietic function were followed regularly in this group, however, of those tested in a random fashion only one revealed an upward change in serum glutamic oxaloacetic transaminase SGOT (38u up to 54u) without any other evidence of dysfunction and subsequent return to below baseline value (24u). Such findings have been repeatedly reported without any definite causal relationship to sulfonylurea agents being noted.^{7,11}

There can be no doubt that the patients in this study were selected and that they received more and probably better attention in a large clinic because

they were participating in a special study. A recent study by Singer and Hurwitz notes the placebo effect of tolbutamide and chlorpropamide in this respect.¹⁹ This factor was probably operative in our initial success rate of 55 per cent of excellent and good results with subsequent attrition at up to two years to 53 per cent. Similar percentages have been reported in most other studies.^{20,24} Although there was about a 30 per cent primary failure rate the number of definite secondary drug failures has been limited to one at the time of this writing.

While it may be justly argued that many of our patients could have been regulated by diet and weight reduction alone, attempts at such therapy had failed repeatedly because of poor patient cooperation and multiple socio-economic problems. The relatively low doses that we were able to use in many patients might also add credence to such an argument and with greater cooperation many might not need oral therapy. The fact remains that the improvement occurring on acetohexamide was definite and had not previously been attained by other means.

Although we attempted to use minimally effective doses in all our patients we found most of our patients needed

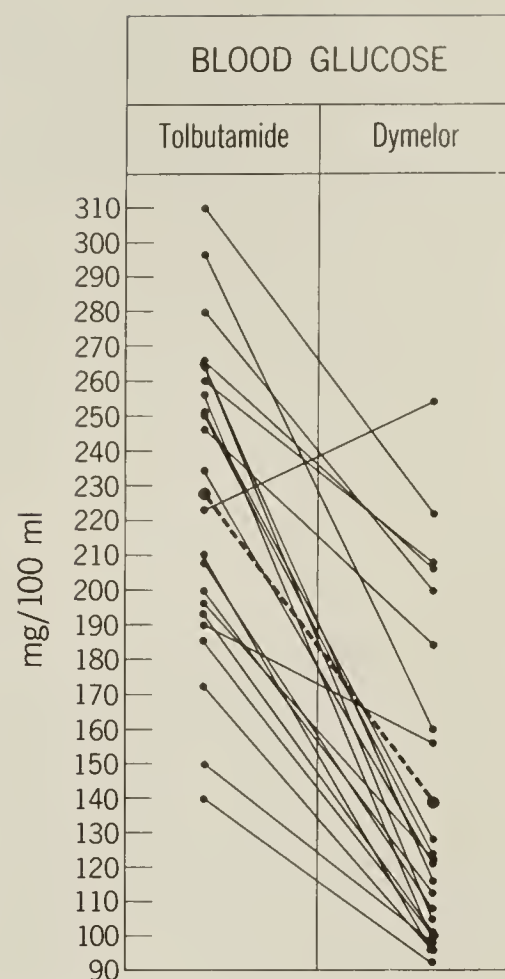


Figure 1. Comparison of fasting blood sugar concentrations on Tolbutamide and Dymelor. The dotted line represents the average change in blood sugar for the twenty-three patients reported.

Table IV

Current status of control of those patients treated with Acetohexamide according to previous oral antidiabetic and its dose.

	<u>excellent</u>	<u>good</u>	<u>fair</u>	<u>poor</u>	<u>failures</u>
Tolbutamide 1 gm	2	2			
1.5 gm	1	1			1
2.0 gm	2	2		1	
2.5 gm	3				1
3.0 gm	1	1	2		3
Chlorpropamide					
150 mg		1			
200 mg	1				
250 mg					1
500 mg	<u>1</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>1</u>
	11	7	2	1	7

500 mg or more per day for control of hyperglycemia. All but five patients who were successfully treated received their total therapeutic dose once a day, a definite advantage in a clinic population that tends to adhere poorly to any complicated treatment regimen. Because of its ease of administration, longer action, smoother course, and relative freedom from toxicity acetoexamide should be considered as the initial form of therapy when or oral antidiabetic agent is indicated.

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Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous

eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
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*References available on request.

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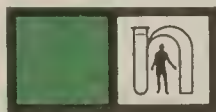
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Admissions Policy at Hershey

DAVID R. OFFORD, M.D.

Hershey

Virtually all of Hershey's students have completed four years of undergraduate college training. Although we do not have any required courses for admission, knowledge in the areas of humanities and behavioral sciences, as well as knowledge in the hard sciences, such as chemistry, physics and biology is recommended. We are impressed if a student has shown the ability to pursue some academic area in depth, whether it be, for instance, in chemistry or biology or in American history or political science. In the class of sixty-four students which started in 1968 have nine pre-meds, twenty-one biology majors, twenty who majored in other sciences, and fourteen who majored in liberal arts or psychology. There are forty-three colleges or universities represented in this class, with Penn State having the largest representation with fifteen. Approximately three-quarters of our acceptances are in-state, and approximately 10 per cent are women. We are considering applications from transfer students for all but our pioneer class.

Let me now take you through, in some detail, our admissions procedure. We begin receiving preliminary applications after June 15 each year. Believe it or not, we received in 1968 2,175 preliminary applications for the sixty-four vacancies. This represents an increase over the 1,100 we received for our pioneer class, and the 1,900 received for our next class. The preliminary application provides information about the background, academic courses, grades, special interests and achievements of the student. This form does not require official transcripts, letters of assessment or other documents. There is no fee requirement for the preliminary application.

The Medical Selection Committee, composed of about a dozen faculty members, reviews these applications and sends formal applications to those persons who seem to have a reasonable

chance for admission. Undergraduate grade-point average and scores on the Medical College Admission Test are factors considered in the initial screening. Very few people with less than a B average are sent formal applications. Our mean MCAT scores for our accepted class members is around 600, about 100 points above the test mean.

We begin our interviews in the early fall. On an interview day six students arrive at the medical center about noon and have lunch with two of our present medical students. The Medical Selection Committee believes this is a highly effective procedure, in that it gives the applicants an opportunity to get the real "low down" on the place, and not be content with hearing only the faculty's view of things. The Medical Selection Committee is most concerned that the prospective student gains an accurate picture of what goes on here, so that he can decide for himself whether this is the kind of medical school that will suit him.

"I emphasize the flexibility of the curriculum, the high faculty to student ratio, and the concern for the students . . ."

The applicants are then given a tour of the facilities after which I talk with them for about half an hour. I try to present as accurately as I can the program here, our strengths and our weaknesses. I emphasize the flexibility of the curriculum, the high faculty to student ratio, and the concern for the students that we on the faculty have. I let them know when they accept a position in our school that they take on certain responsibilities, but emphasize that so do we. Our responsibilities include creating an atmosphere where the emphasis is not on grades so much as on knowing and understanding the material. I point out that we will provide sufficient loan funds so that a student with financial problems does not have to feel overwhelmed by

financial worries during his stay here. The students are then given an opportunity to ask any questions they might have.

"We attempt to guard against one faculty person's opinion determining whether a student is offered a place . . ."

Every applicant is interviewed separately by three members of the admissions committee. Each of the three interviews lasts for about half an hour. By this point, in the admissions procedure, there is little doubt that the student has the brains to graduate from medical school, and the interviews are aimed primarily at evaluating the applicant's personality, his warmth, his concern for humanity, his motivation for medicine, his flexibility, his creativity, and his breadth of interests. Admittedly, the interview is a clinical evaluation and with it comes many strengths and some weaknesses.

If there is a disagreement among the three interviewers about a particular student, he is usually asked to return at another time for two or more interviews with other members of the Medical Selection Committee. The point here is that we attempt to guard against one faculty person's opinion determining whether a student is offered a place or not.

The Medical Selection Committee meetings are not dull. There is controversy over certain applicants. I suspect that each of us on the committee carries a mental picture of what the ideal of medical students should be—much like we are, or more accurately, much like we think we are.

There is one grave disadvantage of being on the admissions committee. That is that the student who is irritating you a good deal this year is the same one nine months ago you defended as being an outstanding candidate for medical school. But, that is a small price to pay for very exciting and rewarding work.



PENNSYLVANIA
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meetings

AUGUST

Germantown Academy Annual Symposium on Sports Medicine, August 13-14, 1970, Germantown Academy Ft. Washington, Pa.

SEPTEMBER

Eastern Pennsylvania Chapter, American College of Surgeons, Conference, September 10-11, 1970, Shawnee-on-Delaware, Pa. Contact Harry G. Light, M.D., Secretary, 65 E. Elizabeth Ave., Bethlehem, Pa. 18018.

Conference on Suffering and Death, Noon to 4 P.M., Thursday, September 17, 1970, Boyd Memorial Center, 234 South St., Harrisburg. For advance information or reservation contact: Rose Levonian, Conference Coordinator, Boyd Memorial Center, 234 South St., Harrisburg, Pa. 17101.

OCTOBER

Pennsylvania Medical Society 1970 Annual Business Session, October 4-8, 1970, Host Farm Resort Motel, Lancaster.

NOVEMBER

Pennsylvania Medical Society Annual Scientific Assembly, November 16-19, 1970, Host Farm Resort Motel, Lancaster.



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Excerpta Media Publications has recently published *Physiopathology of Adipose Tissue* edited by J. Vague. The book is based on papers presented at the International Symposium on Adipose Tissue. It deals with recent advances in the mechanism of lipid biosynthesis, lipolysis and related problems, and metabolic and hormonal abnormalities with particular interest to the secretion of insulin, cortisol, growth hormone and glucagon.

The results of clinical and experimental studies on codeine, widely used analgesic and antitussive agents have been revealed in a publication by Merck & Co., Inc. The hard-cover, comprehensive edition is entitled *Codeine and Certain Other Analgesic and Antitussive Agents: A Review*; a paper-back summary of this review is also available.

The American Medical Political Action Committee (AMPAC) has available a variety of lending library films, pamphlets and books. A short self-training program designed to aid the winning of elections is also available for interested candidates. For further information write for the AMPAC Catalogue, 520 North Michigan Ave., Chicago, Illinois 60611.

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Cardiovascular Surgery - 1970

Part II

Thomas J. E. O'Neill, M.D., Director, Cardiovascular and Thoracic Surgery, and Chief of Section, Episcopal Hospital, Philadelphia is questioned by William G. Leaman, Jr., M.D.

RECENT REPORTS IN THE LITERATURE HAVE DESCRIBED A NEW METHOD FOR BLOCKING EMBOLI IN THE TRIBUTARIES OF THE INFERIOR VENA CAVAE WHICH APPEARS TO PREVENT PULMONARY EMBOLISM. WOULD THIS BE OF GENERAL INTEREST?

Yes. In December, 1969, several articles were published by Kazi Mobin-Uddin and his associates in which they documented their experiences with the placement of a fenestrated "umbrella" into the lumen of the inferior vena cavae, just below the level of the renal veins. This method of treatment was used in a series of fifty patients suffering from thrombophlebitis, pulmonary emboli and in some cases of congestive heart failure, with no resultant complications and no recurrence of pulmonary embolism following the "umbrella" implantation. The operation is done under local anesthesia, which is an advantage in critically ill patients, and can also be performed under heparinization. The technic consists of insertion of the folded "umbrella" into the external jugular vein. By means of its attached manipulatory catheter it is advanced down the vena cava to a position just below the renal veins where it is released from its enclosed capsule. It then fixes itself into the vena caval wall by means of the opened "umbrella" staves. No dislodgements have been reported in this series, and the device promises to be a definite advancement in the treatment of a treacherous complication. The FDA

has ruled this suggested advance as a drug since heparin is bonded to the silicone rubber covering, and it is now commercially available for general use.

KNOWING THAT YOU HAVE BEEN RESERVEDLY PESSIMISTIC ABOUT THE CURRENT PROSPECTS FOR COMPLETE HEART TRANSPLANTATION, WHAT IS YOUR FEELING ABOUT SUCH AN OPERATION?

At once realizing that the human heart is the solitary motor of the entire vascular system, it becomes necessary to consider the many pitfalls that can attend its removal and replacement by the heart of a dying stranger. Setting aside moral, ethical, logistical and monetary considerations, the greatest practical objection is the inherent characteristic of "foreign body rejection." Ordinarily, this rejection mechanism serves as a prime safeguard for the body as a whole. It is a defense mechanism and it manifests itself, as seen through decades of observation, by transforming foreign substances in various ways: viz., expulsion, disintegration, integration and encirclement by encapsulation. While this process might sound like modern warfare, it is, in fact, a kind of biologically orientated battle which is designed to protect the viable organization of the body. Defeat comes to the body only with failure in exploiting these defense mechanisms. Cancer cannot be considered a foreign body since its tissue is recognized in some way as typical of the body itself and, therefore, does not invite the

defense response. It is somewhat like the "fifth column" and, thus, is a more deadly adversary. Consequently, it is unreasonable to expect that a foreign human heart will survive the retaliative assaults that can be brought to bear by

the host individual which recognizes it only as an alien invader. While we can project some hope that immuno-suppressive drugs and more sophisticated tissue matching will, some day, successfully block heart rejection, it is more likely that endeavors will be directed toward the culturing of human or animal fetal hearts beginning before the time of development of tissue specificity. I view such developments with interest but fear that the latter project will blast the hinges off Pandora's box, turning loose the critics, pro and con, and assuring debate more immortal than the subjects themselves.

DO YOU THINK THAT HEART TRANSPLANTATION HAS BEEN PREMATURE?

With our present fund of inadequate knowledge, we serve neither mankind nor science intelligently by repeatedly performing an exercise in defeat. Undoubtedly, the recent marked decline in reports of these misadventures indicates either rethinking, new-found caution or, possibly, retreat before the hammering of the critics' pens. Fundamental research alone must supply the missing links.

William G. Leaman, Jr., M.D. edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

Erratum

In the Cardiovascular Brief of May, 1970 ("Treatment of Essential Hypertension" by Alfred M. Sellers, M.D.), the dosage for chlorthalidone (Hygroton) should read "100 mg. once daily."



Safeguard Against Uterine Cancer

Responding To The Vaginal Smear Report

Significance of the Cytologic Report

The Papanicolaou vaginal smear gives the physician an opportunity to interfere in the natural progression of uterine cancer and often prevent death from this disease. For this reason, to exploit the full potential of this laboratory aid, every vaginal smear report requires a positive action on the part of the physician responsible for the care of the patient.

Types of Smear Reports

Refinement of interpretation over the past twenty years permits the cytopathologist to provide the clinician with a great deal of information other than that of a purely neoplastic aspect. Nevertheless, neoplasia is the most important part of the report and this "Cancer Forum" will confine itself to that question. Although each cytopathologist has his own manner of writing the cytology report, the problem can be simplified by placing all of them in three great categories: negative, suspicious and positive for cancer. The infinite variety of cell patterns that these smears present are of interest to the laboratory but are of no concern to the clinician except insofar as it influences his handling of his patient. It is the responsibility of the cytopathologist to report unusual patterns and advise what actions should be taken.

The Negative Report

There are two types of negative reports. The first is the smear that is normal in all respects. Such a smear should be repeated in one year if the patient is under age thirty-five years. It should be repeated in six months if she is older than thirty-five years. It is not wise to expect the patient to remember

when to come back. Increasing numbers of physicians use a "tickler" file to trigger recall. This is an effective method and appreciated by the patients. The second type of negative report is the one in which there are no neoplastic cells but there is an infection or infestation; especially trichomoniasis. Although the connection between these and the development of cancer is by no means established, many pathologists feel that association of these abnormalities with dysplasia, especially with trichomoniasis, is more than fortuitous. A vigorous effort should be made to eliminate such infections and infestations. Such smears should be repeated in six months or less because of the increased risk.

The Positive Report

It is easy to decide the course of action when a positive report is received. The most commonly accepted procedure is a D & C and conization with the cold knife. At this point it is well to emphasize that the vaginal smear is an adjunct to the biopsy and no definitive treatment should be instituted on the basis of a vaginal smear alone. The biopsy is still the only accepted method of proving the diagnosis of uterine cancer. If the biopsy is reported negative for cancer, the vaginal smear should be repeated as soon as the biopsy site has healed.

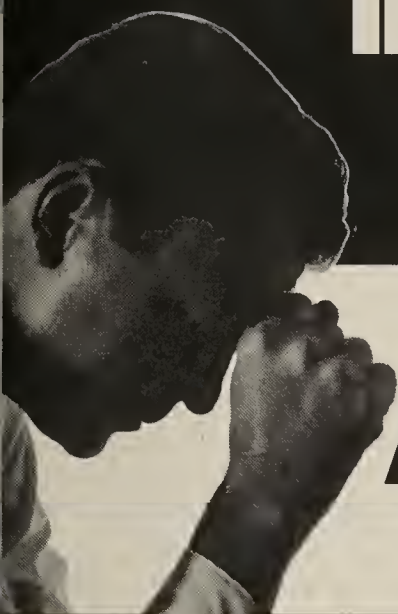
The Suspicious Report

There are two kinds of suspicious reports. The smear suspicious for cervical cancer is handled differently from that suspicious for a fundal carcinoma. A smear suspicious for an epidermoid carcinoma should be followed by conization. Some clinicians and pathologists like to repeat such smears before conization and there is



no serious objection to this practice. If the repeat smear is negative, the patient should have still another smear in one month and again three months after that. If the smears remain negative, she is returned to the recall system suitable for her age group.

When we consider carcinoma of the fundus, we have a much different situation. In contrast to cervical neoplasia where exfoliation is almost a continuous process, desquamation of fundal cells is very capricious. Often the suspicion of fundal cancer is made by indirect evidence and a negative smear after finding a suspicious smear has no meaning. A third important factor is that we are dealing with an older patient and the clinician does not have the time between discovery and invasion that one has in the study of epidermoid cancer. Thus diagnostic curettage represents less risk to the patient than does waiting. Accordingly, curettage should follow a suspicious report without delay when fundal carcinoma is being considered.



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Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Monteleone, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, W. L., Zumeif, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.



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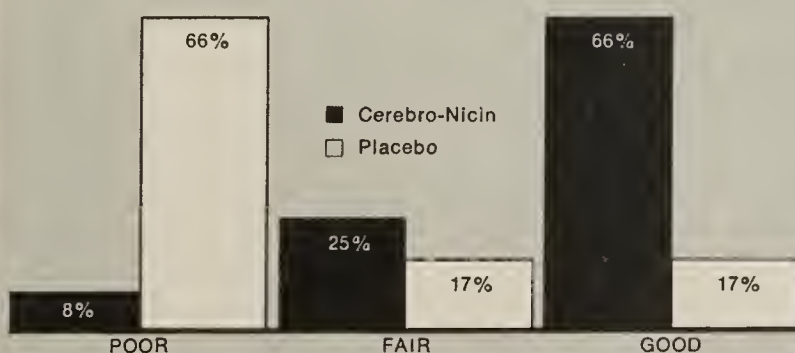
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○ Joseph L. Dennis, Philadelphia; Temple University School of Medicine, 1936; age 57, died January 21, 1970. He was active in the Society for the Advancement of Clinical Hypnosis, a founder and director of the Philadelphia Blood Donors Association and a former director of the Dennis Memorial Hospital. Surviving are his wife, two daughters, two sons and two brothers.

○ Clifford B. Farr, Bryn Mawr; University of Pennsylvania School of Medicine, 1898; age 97, died February 24, 1970. He pioneered in industrial medicine as a consulting physician in the department of diagnosis and research at B. F. Goodrich Co., and later became director of laboratories and research at the Institute of Pennsylvania Hospital. He helped to develop a new approach to early treatment of emotional problems to prevent psychiatric disabilities. His wife and three sons survive.

○ Walter B. Harvey, Asheville, N. C.; University of Pennsylvania School of Medicine, 1929; age 87, died March 17, 1970. Survivors include his wife, a son and two daughters.

○ Edwin S. J. Minner, Egypt; Medico-Chirurgical College, 1910; age 81, died February 25, 1970. He was a former president of the Lehigh County Medical Society. Surviving are three daughters, two sons, one of whom is Roger J. Minner, M.D., and two sisters.

○ Henry Naskow, Marcus Hook; University of Pennsylvania School of Medicine, 1928; age 66, died February 12, 1970. No survivors are listed.

○ Robert G. Pett, Lebanon; Detroit College of Physicians and Surgeons, 1933; age 62, died November 11, 1969. His wife survives.

○ Howard R. Rarig, Berwick; Jefferson Medical College, 1913; age 84, died March 2, 1970. He was a permanent officer of the U. S. Public Health

Service and Veterans Administration. His wife, two sons, one of whom is Howard R. Rarig, Jr., M.D., and a half-brother survive.

○ Homer F. Ray, Jr., Pittsburgh; University of Pennsylvania School of Medicine, 1952; age 43, died March 4, 1970. He served as assistant superintendent of Dixmont State Hospital and prior to that served as acting director of mental health for Alaska and superintendent of the Alaskan Psychiatric Institute. He is survived by his wife, a daughter, four sons and his parents.

○ Harry Salzmänn, Philadelphia; University of Pennsylvania School of Medicine, 1927; age 68, died February 25, 1970. He was associated with the Einstein Medical Center and was a former chief of Surgery at St. Agnes Hospital. Surviving are his wife, two sons, a daughter, a brother and three sisters.

○ Charles W. G. Schaefer, Pittsburgh; University of Michigan School of Medicine, 1928; age 67, died March 8, 1970. His wife survives.

○ William J. Somerville, Rosemont; Jefferson Medical College, 1941; age 54, died March 4, 1970. He was director of student health at the Presbyterian School of Nursing and a former director of arthritis treatment at Graduate Hospital. During World War II he served in the Army Medical Corps and received a Bronze Star. His wife survives.

○ Charles S. Tomlinson, Milton; Hahnemann Medical College and Hospital, 1909; age 80, died March 12, 1970. He was a former president of Lycoming County Medical Society. During his fifty years in practice he became well-known for his work in urology, surgery and leadership in organizing the Evangelical Hospital in Lewisburg. Surviving are his wife and two daughters.

○ William S. Watson, Ormond Beach, Fla.; University of Pittsburgh School of Medicine, 1910; age 83, died March 6, 1970. Survivors include his wife, a son and a daughter.

○ Harry S. J. Whiting, Harrisburg; McGill University, 1921; age 71, died December 1, 1969. He is survived by his wife, two sons, a daughter and a sister.

James F. Henry, Pittsburgh; Howard University College of Medicine, 1933; age 62, died February 8, 1970. His wife survives.

Zung Y. Kim, Philadelphia; College of Medicine, Seoul University, Korea, 1966; age 28, died February 6, 1970. No survivors are listed.

James F. Monaghan, Ardmore; University of Pennsylvania School of Medicine, 1930; age 65, died February 25, 1970. Surviving are his son and daughter.

John E. Moran, Blue Bell; Temple University School of Medicine, 1966; age 29, died March 15, 1970. His wife, a daughter, his mother and sister survive.

Marion Clarke, Bryn Mawr; Johns Hopkins University School of Medicine, 1938; age 86, died January 27, 1970. No survivors are listed.

Salvatore C. Sunseri, Carnegie; University of Pittsburgh School of Medicine, 1917; age 75, died March 7, 1970. A daughter and son survive.

Frank J. Dufner, Jr., Norristown; University of Pittsburgh School of Medicine, 1945; age 49, died February 19, 1970. No survivors are listed.

James A. Harrar, Williamsport; University of Pennsylvania School of Medicine, 1901; age 92, died January 26, 1970. No survivors are listed.

Leonard I. Lapinsolhn, Coral Gables, Fla.; Hahnemann Medical College and Hospital, 1945; age 50, died April 22, 1970. Surviving are his wife, a son, two daughters, his parents and a brother.

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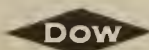
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To: Members, Pennsylvania Medical Society

Subject: NEW BLUE SHIELD PARTICIPATING DOCTOR'S AGREEMENT

Gentlemen:

At its May 13, 1970 meeting the Pennsylvania Medical Society's Board of Trustees considered the new Blue Shield Participating Doctor Agreement which Blue Shield recently circulated to all participating doctors requesting their compliance by August 31, 1970. The Board of Trustees, in recognition of the concern expressed by many of its members about the new Agreement, directed the Council on Medical Service to meet with representatives of Blue Shield.

BACKGROUND

Since the inception of the Prevailing Fee Plan in 1966, there has been increasing criticism of the present Blue Shield Participating Doctor's Agreement which refers only to an agreement to abide by "The Plan". It contains no specific reference to the Prevailing Fee Plan. In December of 1966, Blue Shield wrote to all participating doctors explaining the Prevailing Fee Plan and indicating that Blue Shield would assume the doctor intended to participate in the Prevailing Fee Plan unless otherwise advised by the physician. However, with the offering of the Prevailing Fee Plan to the general public, Blue Shield has now moved to secure formal approval of its participating doctors through the medium of a new Participating Doctor's Agreement which does make explicit mention of the Prevailing Fee Program.

CONCLUSIONS

In its report to the August meeting of the Board of Trustees, the Council on Medical Service made the following points about the new Participating Doctor's Agreement:

1. The Participating Doctor's Agreement applies only to Blue Shield Programs and not to governmental programs.
2. The doctor is not locked in with the new Agreement. There is a thirty (30) day resignation clause.
3. The rules and regulations which accompanied the new Participating Doctor's Agreement do not contain any new provisions, but rather, represent a compendium of present rules and regulations. It was recognized the legal phraseology is irritating to many physicians.
4. The Prevailing Fee Program is a compromise between a fixed fee schedule and open end payment and appears to be the best blend of reasonable control with flexibility of fees for individual practitioners.
5. In order to make the Prevailing Fee Plan a salable product, there must be an element of predictability of cost which is difficult to determine

if the doctors do not agree to the rules and regulations specified in the Participating Doctor's Agreement. Inasmuch as it is estimated that the Prevailing Fee Plan will represent 50 percent of Blue Shield's business within a year, this becomes especially important. Uniform participation by a majority of physicians assures reasonable predictability of cost. This is a key sales feature. The full service benefit provision is particularly vital in union negotiations.

6. Blue Shield is presently the best alternative to a complete government take-over of financing health care costs and Blue Shield needs to know the extent of physician support.

ACTION BY THE BOARD OF TRUSTEES

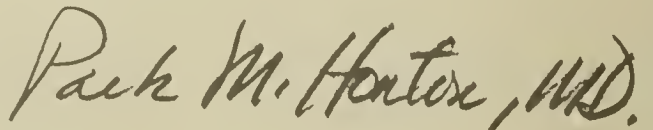
After reviewing the many factors involved, the Board of Trustees took the following action, based on the Council's recommendation:

The Pennsylvania Medical Society continues to approve, in principle, the Participating Doctor's Agreement since Blue Shield will provide the individual doctor's fee profile for specific procedures upon request by the physician; and since Blue Shield has provided to each participating doctor an explanation of the usual, customary, and reasonable (UCR) criteria and its application, and since Blue Shield will prepare a position paper to be distributed to all participating doctors outlining the policy and procedures of the Prevailing Fee Program.

The Board of Trustees also determined to urge Blue Shield to continue to use the 90th percentile method in determining payment of usual and customary fees in lieu of the 75th percentile as proposed by Congress for governmental programs.

In summary, the Board of Trustees, after careful consideration of the report of the Council on Medical Service, finds the new Blue Shield Participating Doctor's Agreement acceptable in principle and believes continued participation by physicians in Blue Shield to be in the best interest of the membership and the public.

Sincerely yours,



Park M. Horton, M. D.
Chairman
Board of Trustees



SEPTEMBER, 1970

SUPPLEMENTAL CALL TO THE 1970 HOUSE OF DELEGATES

At the August 12, 1970 meeting of the PMS Board of Trustees, D. George Bloom, M.D., trustee and councilor from the

Eleventh District, announced his intended resignation following the 1970 Annual Session. All delegates are therefore notified that to the elections announced in the "Official Call" which appeared on page 27 in the July issue of PENNSYLVANIA MEDICINE, is added the following office: "A Trustee and Councilor for the Eleventh Councilor District to serve for one year to complete the unexpired term of D. George Bloom, M.D., Cambria County, who has submitted his resignation effective at the close of the 1970 Annual Session." Society Secretary Raymond C. Grandon, M.D., issued the above Supplement to the Official Call.

BOARD RESCINDS ACTION ASKING FOR POSTGRADUATE MEDICAL EDUCATION

The Board of Trustees at the August 12 meeting rescinded an action taken at the May meeting

recommending to the House of Delegates that members must take 150 hours of postgraduate education every three years and qualify for the AMA Physician Recognition Award in order to retain PMS membership. In rescinding its action, the Board acknowledged some benefits of such a requirement, but felt that it would be premature to urge its adoption at the 1970 House of Delegates. As a result of this action the summary of the annual report of the Board of Trustees and Councilors which appears on page 50 of this issue of PENNSYLVANIA MEDICINE inaccurately reports favorable action. The summary section was on the press at the time of the August 12 meeting.

SOCIETY ROSTER NOW AVAILABLE

The 1970 PMS Roster, containing a list of county society officers, members listed in alphabetical order and-- for the first time-- specialty information is now available. PMS members are entitled to a complimentary copy. Additional copies are available at \$10.00 a copy. Non-members and organizations may order copies at the same cost. Orders should be sent to: Membership Department, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

STATE HOSPITAL SLATES THIRD CHILDREN'S MEET

The State Hospital for Crippled Children has scheduled a one-day meeting beginning at 9:15 a.m., October 3 at the hospital on the theme: "Management of Traumatic Quadriplegia in Children." Reservations must be made by September 30. A full program is available from the State Hospital for Crippled Children, Elizabethtown, 17022.

PMS AND HOSPITAL ASSOCIATION TO CO-SPONSOR MEETING

The Hospital Association of Pennsylvania and the Pennsylvania Medical Society are co-sponsors of a meeting at 9 a.m. September 30 at the Penn Harris Motor Inn to discuss revised standards for accreditation of hospitals. HAP is accepting reservation Registration fee is \$10.00.

FOUNDATION CONCEPT
APPROVED BY BOARD

Approval of the concept of a Pennsylvania Medical Care Foundation has been granted by the PMS Board of Trustees and the plan, with further development, will be presented for concurrence to the October meeting of the House of Delegates. The Council on Medical Service recommended the action. The council's report said that the foundation concept as an alternative to present means of financing health care appears to be desirable because public pressure is fostering the development of the prepaid closed panel concept on the basis that such plans generally reduce the rate of hospital usage. Preliminary guidelines were developed by the council in consultation with Pennsylvania Blue Shield. The Pennsylvania proposal, if established, would be the largest in the nation.

AUGUST 'TESTIMONY MONTH'
FOR SOCIETY OFFICERS

PMS representatives presented the views of the State Society on a variety of issues during the past month. On August 12, John H. Harris, Jr., M.D., chairman of the Council on Governmental Relations, testified on the PMS opposition to the Pennsylvania Health Agency proposal before the House of Representatives Consumer Protection Committee. PMS President William A. Barrett, M.D., presented the State Society's health care position paper at a Republican Party Platform Committee hearing in Pittsburgh August 11. A week later Dr. Barrett testified before the House Committee on Health and Welfare concerning the proposed merging of health and welfare agencies in the state in one Department of Human Services. PMS President-Elect William A. Limberger, M.D., presented the PMS position on the same subject at a meeting of the State Government Task Force on Human Services the next day.

ABORTION LAW
CHANGE URGED

A bill that would broadly define a legal abortion as one performed by a physician at the request of a patient will be recommended for support at the Annual Session of the House of Delegates by the Board of Directors. Currently the law does not define legal or illegal abortion. The bill, House Bill 2393, Printer's No. 3189, is not equated with "abortion on demand" legislation. Individual physician response to it, if passed, will be determined by local hospital staffs and medical societies throughout the state.

PRACTICE ACT
STUDY BEGINS

PMS Board Chairman Park M. Horton, M.D., has appointed three doctors to a special committee of the Board of Trustees to meet with the State Board of Medical Education and Licensure concerning revisions in the Medical Practice Act. Committee members are: William J. Kelly, M.D., Pittsburgh; John H. Killough, M.D., Philadelphia; and Edgar W. Meiser, M.D., Lancaster.



Corticosteroid therapy week after week. then antibiotic therapy last week. and monilial overgrowth this week.

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin
where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin— maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney— rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions— urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.



PENNSYLVANIA MEDICINE

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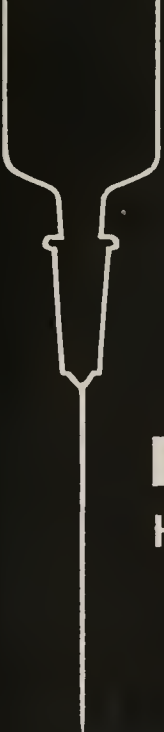
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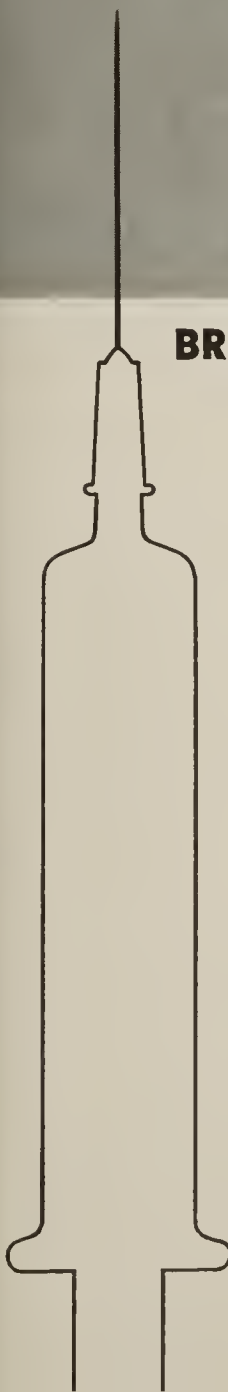
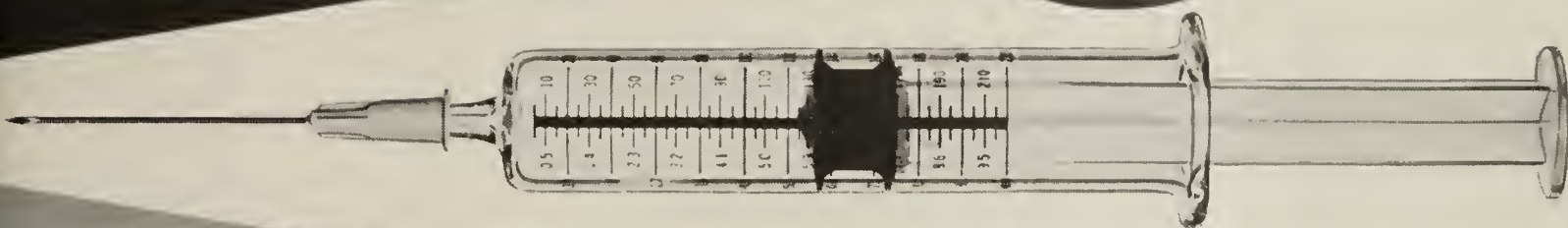


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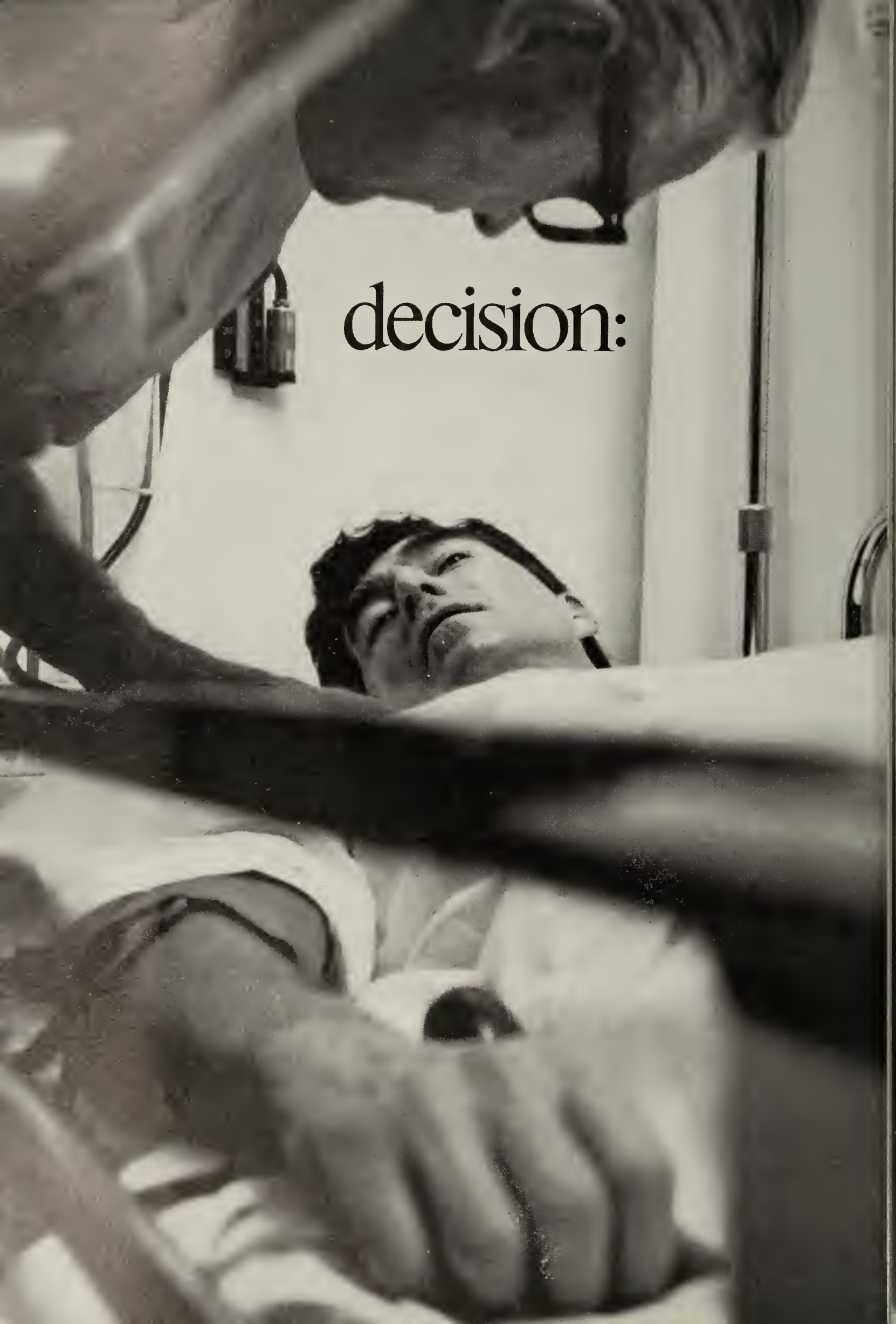
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moderately severe
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 - infections following compound fractures
 - urinary tract infections
- broad-spectrum activity
- relatively painless I.M. injection
- logical I.M. follow-up to I.V. cephalosporin therapy

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



000904

Loridine[®]
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

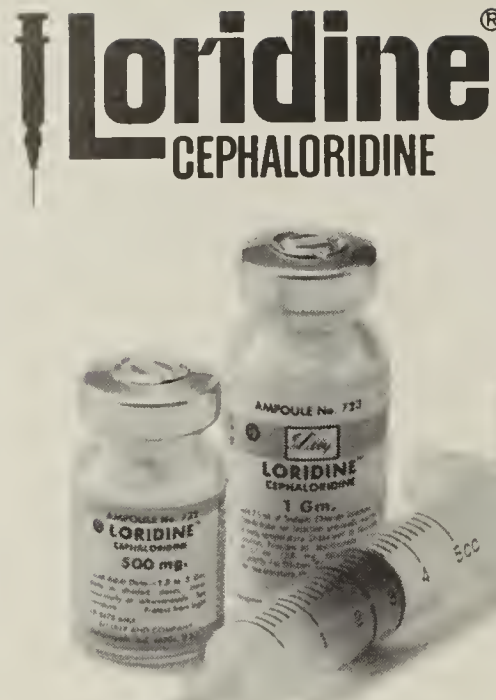
Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-



Loridine®
CEPHALORIDINE

**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

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Physician and Teacher

To Receive

PMS Distinguished Service Award

"I can tell you this, he is truly a great man." In this manner a colleague of Eugene P. Pendergrass, M.D., who is to receive the Distinguished Service Award of the Pennsylvania Medical Society next month, described him.

A physician for fifty-two years, he spent all those years at the University of Pennsylvania, and its medical school, from which he graduated in 1918.

But this tells nothing of the eminent radiologist who will be celebrating his seventy-fifth birthday on October 6, the date on which he will be honored by the Pennsylvania Medical Society with an award which has been given only three times before.

A rare physician and a teacher of great stature, Gene Pendergrass has about him an electric quality. It is this which motivates him to tackle mountainous problems, and reduce them to movable objects. It is this which made of him, following his training in radiology under Henry K. Pancoast, M.D., one of the truly great teachers of his time.

'... I learn so much myself in the process of teaching.'

His role as a teacher is considered by many to have been the reason he was selected for the award he will receive next month.

Gene Pendergrass says of himself: "I like teaching mainly because I learn so much myself in the process of teaching others." He considers his monumental bibliography of more than 286 published papers and books an extension of his role as a teacher. He is emeritus professor of radiology at the University of Pennsylvania School of Medicine and Graduate School of Medicine, and served as director of the Department of Radiology at the Hospital of the University of Pennsylvania from 1939 until 1961. He followed in the footsteps of Dr. Pancoast, his friend, mentor and co-worker, who was the first director of the Department of Radiology at the hospital.

He speaks with devotion of Pancoast, with whom he co-authored a number of his early scientific papers. "He treated me as a son at the time he was training me in radiology. I lived in his home for a time prior to my marriage," Dr. Pendergrass reminisced.

Immediately following his graduation from medical school, Gene Pendergrass joined the Navy. The United States had entered World War I, and he saw himself serving his nation on the high seas. But the Navy saw him serving his nation in Philadelphia, in the hospital where he had interned, learning the new discipline of radiology from Pancoast. "I was disappointed by the assignment, because I felt it was a waste to go through medical school

only to be assigned to what was at that time considered "picture-taking."

'Radiology . . . now has the function of recording dynamics in almost every organ of the body.'

He says of radiology now: "This is the only true 'general practice' of medicine. The radiologist sees and diagnoses all kinds of ailments. The contribution radiology has made to curing disease is fantastic. Radiology has had a fabulous growth in a relatively short time. In the beginning radiology was largely oriented to recording structure in its various normal and abnormal manifestations. Now it has the function of recording dynamics in almost every organ of the body. It has pushed the frontiers of medicine in many areas so much so that now physicists, electronic engineers, biologists, physiologists, chemists, mathematicians, statisticians, pharmacologists and anthropologists all are involved in the program of which radiology is the basic discipline."

He points with pride to the fact that those involved in the work of the radiology department at the hospital identify with the radiologists. "Nurses, technicians, engineers, secretaries and receptionists all recognize that their role is as vital as the chief role. And we call on experts in the fields I've already talked about to help us, and we



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Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.

I see as a worthy theme

for the bicentennial a

massive effort to solve

all of our environmental

problems . . . This

would make the 200th

anniversary of

the founding of this

nation a rebirth.'

consider them our equals. For example, since there have been radiobiologists, we have been able to do a better job of interpreting the affects of radiation on the cell and on the total body. The other disciplines in medicine must learn to rely on such aid to relieve the physician shortage."

Eugene Percival Pendergrass was born in Florence, South Carolina, where he spent his boyhood. A career as a cotton buyer seemed likely for him when he entered Wofford College in his home state, but medicine drew him and he transferred to the University of North Carolina at Chapel Hill, where he spent two years preparing to enter the University of Pennsylvania School of Medicine. He reminisces about his boyhood and his home state with devotion, calling on a magnificent memory to draw word pictures of both, but his love for the University of Pennsylvania and its hospital is fierce in its intensity. He identifies with both, and it is difficult for those who know him to think about either without thinking also of Pendergrass.

The young Dr. Pendergrass married Rebecca Barker, of New Brighton, Pa., in 1922. Everyone who knows this eminent and world-renowned physician notes his devotion to his lovely "Betty." He says simply, "If Betty Pendergrass had not been my wife, I could not have done anything."

The couple had three children. Their first-born, Henry Pancoast Pendergrass, M.D., has followed the path of his namesake and of his father. He is professor of radiology at Harvard University School of Medicine, and radiologist at Massachusetts General Hospital. Two daughters completed the Pendergrass family. The elder, Jane, died in 1966. Margaret, the younger, lives with her husband and son in the midwest. There are eight grandchildren, and the amazing Dr. Pendergrass gives every indication of having bridged a double generation gap in relating to them.

The doctor's memory for details from his distinguished career might well supply material for a truly great biography. Throughout his life, while serving the university and the hospital, he also served his country and his adopted state, and he is proud of it. The list of appointments he has had

and awards received is overwhelming. He has served as president of the American College of Radiology, the American Cancer Society, the Radiological Society of North America and the Philadelphia Roentgen Ray Society. He has served on numerous boards and commissions in scores of organizations, and has acted as consultant to more than fifteen hospitals throughout eastern Pennsylvania.

He served as consultant to the United States Public Health Service, the Pennsylvania Department of Health, the Armed Forces Institute of Pathology, and the Naval Hospital and Veterans Hospital, both in Philadelphia.

He is a true navy man, proud of wartime service, but as a scientist, more deeply concerned about what he learned while serving the Atomic Energy Commission as a member of the Atomic Bomb Casualty Commission.

He served as a member of the Operation Crossroads Safety Committee in 1946, and visited the Bikini Atoll to study the effects of atomic bomb testing. He was a member of the Central Advisory Committee on Radiologic Defense for the Office of Civil Defense. He served as consultant to the Department of Radiology, Atomic Bomb Casualty Commission, and the Hiroshima and Nagasaki Branch Laboratories of the Japan National Institute of Health.

Hiroshima and Nagasaki are not names from a history book to him. They are symbols of events which he doesn't want to reoccur. He is determined to convince others to work to this end yet he is a practical man, and speaks of planning cities so that in the event history is repeated, humanity will survive.

Gene Pendergrass is a firm believer in work, which is why he has been as busy as ever since his retirement.

He has faith in people. "We can lick the problems," he says in reference to the social ills of the twentieth century. "If by working together people can solve problems such as those faced on the last moon flight in order to bring back the astronauts safely, then by working together, men can solve the earth's problems.

"I see as a worthy theme for the bicentennial celebration a massive effort to solve all of our environmental problems, not only air and water

pollution and solid waste management, but also ghetto housing, poor nutrition, alcoholism, mental illness and drug abuse. I see the medical profession joining hands with the universities, clergymen and all those concerned with or plagued by these environmental problems in order to find solutions.

This would make the 200th anniversary of the founding of this nation a rebirth."

This doctor also has faith in God. He states it simply, this man whose brother is a bishop of the Methodist Church, "How else could a country boy from South Carolina be sitting here talking about such a rich life, and and looking forward to a better world".

He is known by his colleagues as a clinician of the highest order -- a physician who has been able to stir up a desire to live in individuals whom others have given up as hopeless. He has given hope, comfort and support to innumerable patients through the years.

Kidney Program Establishes M.D. Information Centers

The Greater Delaware Valley Regional Kidney Program, a project of the University City Science Institute in Philadelphia, funded by the Greater Delaware Valley Medical Program (GDVMP) is currently engaged in setting up two different information centers for the benefit of regional physicians. These centers are to aid the physician in locating a dialysis training facility or an institution that can provide chronic treatment and a center for tissue registry and blood typing data on all potential candidates for kidney transplants.

To utilize the registries any physician having a patient in need of dialysis therapy and wishing to use the facilities of the Greater Delaware Valley Region can call the office of the Regional Kidney Program for information on bed vacancies. The number to call for this service is (215) EV 7-2255, extension 65, Monday through Friday from 9 a.m. to 5 p.m.

If you should have under your care a patient with what you consider a terminal medical or surgical illness and normal kidneys and desire more information about the Greater Delaware

Radiological research, particularly investigation into silicosis and pneumoconiosis, has brought him world-wide fame. He has been awarded the gold medal of the American College of Radiology in recognition of this work.

But it is as a teacher that Eugene P. Pendergrass reached the pinnacle of his career. The word doctor has its root in the Latin verb "to teach." This is what Dr. Pendergrass has done as he transmitted his enthusiasm for his work to his students. They stand in testimony thereof--almost 200 radiologists throughout the world trained by him. After World War II these men joined to organize the "Association of Pendergrass Fellows," and the group meets fairly regularly, usually at the Homestead in Virginia. The meetings are scientific sessions, but the presence of wives and family make them family reunions.

For a period the Pendergrass Asso-

ciates even published a newspaper called "Grass Roots." But in the eyes of the man who has been their inspiration, the Pendergrass Associates' crowning glory was an invitation from the Rocky Mountain Radiological Association to conduct the entire scientific session of that organization. He smiles and his blue eyes throw sparks as he looks back over life which has had a full share of peaks of happiness and valleys of sorrow. He is a man who knows how to accept, but not how to give up.

In receiving the Distinguished Service Award of the Pennsylvania Medical Society, Eugene P. Pendergrass, M.D., joins three great Pennsylvania physicians, the only other recipients of the award: Jonas Salk, M.D., developer of poliomyelitis vaccine; John H. Gibbon, Jr., M.D., who perfected the heart-lung machine for use in open-heart surgery; and James Z. Appel, past president of the AMA.

\$1.4 Million Grant Made to WPRMP

A grant of over \$1,433,000 was issued to the Western Pennsylvania Regional Medical Program by the Health Services and Mental Health Administration of the Department of Health, Education and Welfare. This grant will support health care planning, two new health care projects, several pilot studies and continue to fund five projects previously supported in the area.

Robert R. Carpenter, M.D., program director, feels that this high level of funding is an indication of strong federal support.

Family Practice Board Sets Examination Dates

The second examination for certification will be given by the American Board of Family Practice at various centers throughout the United States. The examination will be over a two-day period on February 27-28, 1971. For information regarding the examination and eligibility for the examination write to: Nicholas J. Pisacano, M.D., Secretary-Treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506. The deadline is Nov. 1.

Valley Cadaver Utilization Program call (215) 382-6888. There is a pressing need for such cadaver donors. This project is also funded by the GDVMP.

Rural Health is Conference Topic

Rural leaders throughout the state will gather for the Pennsylvania Conference on Rural Health on September 18 at the Penn Harris Motor Inn, Camp Hill. Speakers at this conference will be William A. Barrett, M.D., president, Pennsylvania Medical Society, Donald E. Harrop, M.D., Charles J.H. Kraft, M.D., J. Mostyn Davis, M.D., Arthur D. Nelson, M.D., and Katherine B. Hess, M.D., Pennsylvania Department of Health.

The Pennsylvania Medical Society sponsored conference will be an all-day session featuring information on physician recruitment, methods of financing community facilities and the health care problems facing rural Pennsylvanians. Interested physicians should contact the Advisory Committee on Rural Health, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043.

ACP Pushes Plan to Cut Hospital Costs

The American College of Physicians (ACP) in a recent statement urged its 16,000 members throughout the country to eliminate the duplication of equipment, services and personnel among private, voluntary and public hospitals in an effort to control the rising costs of medical care in the United States.

The ACP board in another statement exposed the view that federal support of the medical school teaching programs is "erratic, sporadic and inadequate." There is an urgent need for more physicians and better health care in the nation. To educate more practitioners, more teachers are necessary. Despite the professional and medical school's efforts to meet the demand they are impeded by inadequate financial support.

The federal government has given priority to production of health manpower, but, the ACP said, it is concerned with the cutbacks in health appropriations which will adversely affect efforts of the profession and schools.

Research programs, which are invaluable to effective medical school teaching, have received strong governmental backing although an increase in research support is lacking. What would be most efficient is a balanced teaching and research program in the medical schools.

The three federal programs the ACP deems important to the future of medical education are direct support of medical teaching, support of medical research and fair payment of teachers for services to patients.

Rubeola Increases

The Pennsylvania Department of Health has announced that there has been an increase in the number of incidences of rubeola. In 1969 there were six times as many cases as were reported in 1968. Previously, however, there had been a decline in the rate of occurrence after the licensing of rubeola vaccine after 1963.

In Philadelphia where a comprehensive immunization program continues there continues to be a decrease in the number of cases of the disease.

Drug Control Program Has New Adviser

Catherine B. Hess, M.D., Harrisburg, has been appointed medical advisor for the drug control program of the Pennsylvania Department of Health by Secretary of Health Ellsworth R. Browneller, M.D. She was formerly director of chronic diseases



DR. HESS

for the health department. As advisor to the drug control program Dr. Hess will provide full-time medical consultation services.

Dr. Hess was narcotics coordinator for New York City and between 1962 and 1965, by establishing a narcotics registry she recorded 50,000 addicts, had provided many with detoxification treatment and set up a day care center to assist former addicts in total rehabilitation.

Commision Sends Draft

The State Air Pollution Commission has sent the initial draft for achieving strict new air quality standards for seven western Pennsylvania to interested groups for review. The plan should reduce dust particles by about 82 per cent and sulfur dioxide emissions by 74 per cent within three to four years.

Grants to Assist Treating Alcoholics

Federal grants to assist in comprehensive alcoholism treatment and rehabilitation were made available July 1 to local communities by Roger O. Egeberg, M.D., assistant secretary for Health and Scientific Affairs. This grant makes possible the development of a national network of community-based treatment and rehabilitation programs for alcoholics.

The grants will help to cover the salary costs of professional and technical staff. Limited funds will also be available for construction of alcoholism treatment facilities. Agencies receiving grants must offer a comprehensive alcoholism treatment program with five essential services. These are in-patient hospital care; out-patient services; intermediate services, such as partial day or night hospitalization; twenty-four hour emergency service; and consultation and educational services related to prevention and treatment of alcoholism.

Blue Shield Membership Increases by 3 Million

The National Association of Blue Shield Plans (NABSP) recently released its 1969 Annual Report which showed an increase in membership by over 2.6 million persons in the seventy-four Blue Shield Plans.

Blue Shield President John W. Castellucci stated that Blue Shield was providing coverage for 31.25 per cent of the population in the United States.

Mrs. Jacob Ripp

Mrs. Jacob Ripp, past president of both the Allegheny County Medical Society Auxiliary and the Woman's Auxiliary to the Pennsylvania Medical Society died recently in Pittsburgh. She was one of the original members of the Board of Directors of the Pennsylvania Medical Political Action Committee, an eastern regional chairman of the Woman's Auxiliary of the American Medical Association and a member of the Allegheny Chapter of the American Red Cross Nursing Service Advisory Committee.

SOCIO ECONOMIC SEMINAR

'MALPRACTICE IN THE EMERGENCY ROOM'



TUESDAY, OCTOBER 6

2 - 4 P. M. MONTE CARLO ROOM

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Dramatization and Question and Answers

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MITTEE OF THE PENNSYLVANIA MEDICAL SOCIETY

CASE PRESENTATION

Defendant:

Philip K. Hensel, M.D.,

Member—Medical-Legal Committee of
Dauphin County Medical Society, Guest
Lecturer in Law and Medicine, Dickinson
School of Law.

Moderator:

Irwin Benjamin, Esq.

Partner—Hurwitz, Klein, Benjamin &
Angino, Harrisburg, President-Elect, Penn-
sylvania Trial Lawyers Association, Pre-
sident—Dauphin County Bar Association.

Attorney for Plaintiff:

Thomas B. Rutter, Esq.

Partner—Litvin & Rutter, Philadelphia,
Member American and Pennsylvania Trial
Lawyer's Associations; Member—Philadel-
phia, Pennsylvania and American Bar
Associations.

Attorney for Defendant:

William J. O'Brien, Esq.

Partner—Pepper, Hamilton & Scheetz,
Partner—Pepper, Hamilton & Scheetz,
Philadelphia, Pennsylvania and American
Bar Association, Member—Medical-Legal
Committee of Philadelphia Bar Associa-
tion.

Merger of USP and National Formulary Possible

A merger between the United States Pharmacopeia (USP) and the National Formulary (NF) was discussed recently by officials of the United States Pharmacopeial Convention, Inc. and the American Pharmaceutical Association (APhA) at APhA headquarters.

Two Pennsylvania doctors represented the USP at the convention. They are USP President John H. Moyer, M.D., of Philadelphia and Chairman of the Board of Trustees Paul L. McLain, M.D., Pittsburgh.

An agreement was made to develop a master plan for a cooperative venture between the USP and NF, which both groups' Boards of Trustees would consider.

At an earlier spring meeting of the United States Pharmacopeial Convention, a resolution had been adopted urging intensified efforts "to coordinate the activities and programs of the USP and NF, and to explore the advantages and feasibility of unification of these activities and programs with the objective of producing a single compendium of standards and tests for official drugs and dosage form."

Doctors Working Longer, Earning More AAGP Says

The American Academy of General Practice recently completed a random sample survey of family doctors in the United States. The survey shows that doctors have increased their income since Medicare and Medicaid began in 1966. At the same time however, the survey shows that the average number of hours worked per week has increased by 15 per cent to fifty-nine hours per week.

The survey shows that, while the number of hours worked per week and the number of patient visits per week have gone up considerably for many of these doctors, the time spent per patient has remained about the same.

The most significant general conclusion the survey produced is that the more a doctor works, the more he can earn, but not in a direct ratio to additional hours worked.



A REPORT on the organizational meeting of the PMS Interspecialty Committee (shown above) was delivered to the Board of Trustees at its August 12 meeting by Robert S. Pressman, M.D., Philadelphia, who was elected chairman of the committee. Leonard F. Bush, M.D., Danville, was elected vice-chairman. In his report Dr. Pressman informed the Board of Trustees that seventeen of the eighteen specialty groups which are entitled to representation had delegates present. The Interspecialty Committee will hold its next meeting during the PMS Scientific Assembly, at 9 a. m., November 18, 1970 at Host Farm Resort Motel, Lancaster.

VD, Hepatitis Major Health Problems Allegheny County Study Shows

Venereal disease and hepatitis still are major public health problems in Allegheny County, according to the County Health Department's Communicable Disease Report for June, 1970.

Gonorrhea, the most prevalent form of venereal disease in the county, has increased 20 per cent over last year. From January to June of this year, 1,084 cases were reported, compared to 832 cases during the same period in 1969.

Hugh Robins, M.D., chief of the Bureau of Medical Services, attributes the high rate of gonorrhea to two factors: venereal disease rates generally are higher in the summer, and gonorrhea is much more difficult to detect than syphilis, particularly in females.

Another cause of concern for county health officials is the continued increase in hepatitis. Infectious hepatitis cases have nearly doubled from last year, with a total of 177 cases reported from January to June,

1970, compared to 94 cases reported during the corresponding period in 1969.

Dr. Robins noted that hepatitis increased sharply during the past two years, particularly among young adults. He attributed the increase to lowered standards of personal hygiene among young adults and widespread use of drugs, especially those taken by puncturing the skin.

HEW to Study Plan To Use Retired Doctors

The Department of Health, Education and Welfare recently announced that the Division of Physician Manpower would fund a study of a plan to use retired medical professors in hospitals in critical need of consultants for patient care and teaching professors. The study will be conducted at Saint Barnabas Hospital in New York City under the guidance of Joseph Moldaver, M.D.



Sandoz announces...

a new agent for
the alcohol-dependent patient
who wants to quit

and

a program for the Pennsylvania physician
who wants to help



When alcohol becomes a way of life



new **SERENTIL**[®] (mesoridazine)

a major tranquilizer with specific advantages for the alcohol-dependent patient:

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in Pennsylvania*

State Rank

total no. alcoholics	4th
no. per copito	12th
per copito consumption†	27th

Pennsylvania Physicians' Report (compared with U.S. average)

	%Pa.	%U.S.
see 5 or more problem drinkers in 2-month period	32.8	37.1
half or more seen ore women	33.8	37.4
treat, rother than refer	72.7	72.6
more community services needed	62.8	63.0

*based on preliminary data supplied by Center of
Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory**, a nationwide survey of treatment centers.

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See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states.

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

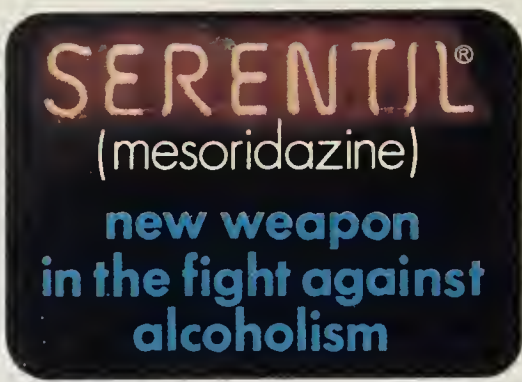
Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least 1/2 hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few



(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible.

There is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arrest, has been noted.

Extrapyramidal Symptoms: Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, akinesia—some of which on rare occasions have persisted for several months or years especially in patients of advanced age with brain damage.

Endocrine Disturbances: Menstrual irregularities, altered libido, gynecomastia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxical reaction have been reported.

These include excitement, bizarre dreams, aggravation of psychoses and toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long-term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclera and cornea. Opacities of the anterior lens and cornea described as irregular or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dosage of Serentil (mesoridazine), as in most medications, should be adjusted to the needs of the individual. The lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to a maintenance level.

Alcoholism: For most patients the usual starting dose is 25 mg. b.i.d. The usual optimum total daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless of severity, a starting dose of 50 mg. t.i.d. is recommended. The usual optimum total daily dose range is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: For most patients a starting dose of 25 mg. t.i.d. is recommended. The usual optimum total daily dose range is 75-300 mg. per day.

Psychoneurotic Manifestations: For most patients the usual starting dose is 10 mg. t.i.d. The usual optimum total daily dose range is 30-150 mg. per day.

Injectable Form: In those situations in which an intramuscular form of medication is indicated Serentil (mesoridazine) Injectable is available. For most patients a starting dose of 25 mg. is recommended. The dose may be repeated in 30 to 60 minutes, if necessary. The usual optimum total daily dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg. and 100 mg. mesoridazine (as the besylate). Bottles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besylate)]. Inactive ingredients—Disodium Edetate U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg.; Carbon Dioxide Gas (Bone Dry), q.s.; Water for Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 100.

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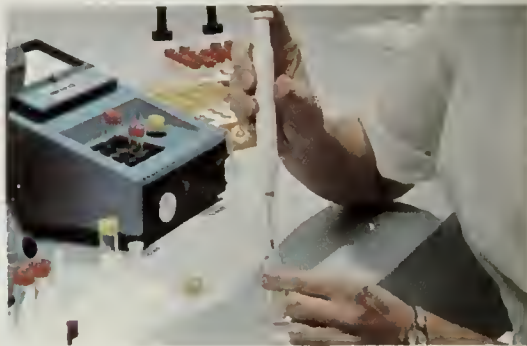
sistent serum, plasma and hemato-crit results at 10,000 rpm. Other preparations requiring graduating intermediate speeds may also be conducted. Select-a-Fuge 24 does all this without changing equipment, without adding or removing parts.



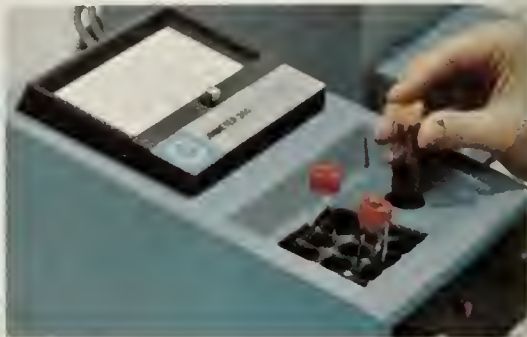
Built-in Incubator — The Unimeter has a convenient built-in incubator which holds twelve tubes at a constant temperature of 37°C. There is an instant push-button temperature check.



Interchangeable Meter Faces—The slip-in meter face cards with color-coded test scales allow the operator to adapt this unit to a variety of tests and to incorporate any new tests which may be added in the future.



Push Button Pipetting—Automatic Pipette controls critical measurements precisely with remarkable ease and speed. Assures dependable results between operators, regardless of their individual skills.

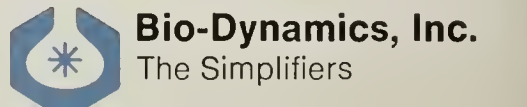


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Internists Offer Program for Senior Citizens

The Pennsylvania Society of Internal Medicine (PSIM) has prepared and is sponsoring a public information program for senior citizens which has been planned for several locations throughout the state. The first pilot program was presented recently to the Senior Citizens Club of the Hazleton YWCA. Approximately 150 senior citizens of this organization formed an enthusiastic audience.

The program was arranged by Peter Saras, M.D., treasurer of PSIM. Dr. Saras also acted as moderator. Others on the panel consisted of Richard Hutsko, field representative for Social Security Administration in the Hazleton office, Clyde Collins, manager of Beneficiary Services, Pennsylvania Blue Shield, Raymond Crisci, credit manager of St. Joseph's Hospital in Hazleton, and James Collins, M.D., past president of PSIM who spoke on "The Physician's Viewpoint of the Medicare Program." His remarks concerned peer review mechanisms, hospitalization, and extended care facility restrictions as imposed by utilization programs. Each of the other participants discussed programs pertinent to their organizations and of interest to the senior citizens' group.

A question and answer period followed the formal presentation of each speaker. At the termination of the program, the participants taped the proceedings at the Hazleton Broadcasting Station and the following morning a forty-five minute presentation was aired over WAZL-AM/FM, Hazleton.

Private Practice Institute To Study Economic Factors

The Association of American Physicians and Surgeons has planned a nationwide Private Doctors Institute for September 30, 1970, in Richmond, Virginia. This is the first such program that will involve itself with financial, legal and economic factors affecting doctors in a practical, rather than theoretical, manner. The program takes place on the first day of the Annual Meeting of the Association of American Physicians and Surgeons to be held September 30 through October 3, 1970 at the John Marshall Hotel.



PARTICIPANTS IN THE PSIM program for senior citizens included, left to right, Carl Bonfils, James Collins, M.D., and Peter Saras, M.D. In the back row, left to right, are Raymond Crisci, Richard Hutsko and standing right, Clyde Collins.

Air National Guard Seeks Doctors

For the first time in many years the Selective Service requisitioning cycle for physicians has been discontinued temporarily in so far as the Pennsylvania Air National Guard (PaANG) is concerned. This permits the appointment in the PaANG of non prior service physicians who have completed their internship to satisfy military service obligations. Several vacancies in medical units within Pennsylvania exist.

Generally, appointees are initially tendered the position of captain. Within a reasonable time after commissioning, the new medical officer will be expected to attend a twelve-day medical officer basic orientation course conducted at the School of Aerospace Medicine in San Antonio, Texas. Medical officers qualifying for flight surgeon's rating will spend fifteen days participating in the flying program.

Further information pertaining to the Air National Guard Medical Service may be obtained by writing to Lt. Colonel Harold E. Pierce, Air Surgeon

Headquarters PaANG, Department of Military Affairs, Annville, Pennsylvania 17003.

RMP In N.Y. Maintains Training Aids Library

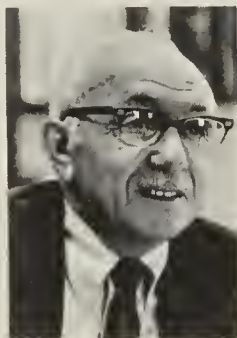
The Learning Resources Center of the Central New York Regional Medical Program has established a lending library of video tapes, films, audio-tapes, slides and other training devices for health agencies so that health professionals may have the latest medical advances directly from nationally known specialists without inconvenience. The regional medical program feels that this is the most effective way of providing its staff members with the means for studying these advances, and so aid in providing the best possible medical care.

The biggest advantage will be for the smaller institutions who would otherwise not be able to provide any staff continuing education due to lack of funds, instructional personnel and know-how.

Dr. Lucchesi to Leave Einstein Posts

Pascal F. Lucchesi, M.D., executive vice-president and medical director of the Albert Einstein Medical Center, Philadelphia, relinquishes his posts January 1, 1971. He will remain a consultant for the medical center. Succeeding him as executive vice-president is Robert M. Sigmond, presently executive vice-president for planning at the medical center.

Dr. Lucchesi has held his present post since 1952 when the medical center was formed. He has received numerous awards and appointments. He is a past president of the Philadelphia County Medical Society and past



MR. SIGMOND **DR. LUCCHESI**
president of the Hospital Association of Pennsylvania. He is the vice-chairman of the Educational and Scientific Trust of Pennsylvania Medical Society and has been honored with the Philadelphia County Medical Society's Strittmatter Award for outstanding service to medical education and public health.

Mr. Sigmond is a nationally known expert in the health care planning field and a past executive director of the Hospital Planning Association of Allegheny County in Pittsburgh. He has also served as a consultant to the Secretary of Health, Education and Welfare's Committee on Hospital Effectiveness, and as a consultant to the United States Public Health Service and the Office of Economic Opportunity. He is also professor of health administration at Temple University School of Business.

Malaria, Typhoid Grow

Two communicable diseases, malaria and typhoid fever, have increased in the United States in recent years. The Pennsylvania Department of Health attributes these incidences to the Vietnam war and increased vacationing in foreign lands.

Health Department Hunts Clues In Encephalitis Virus Mystery

A State Health Department team is looking for some answers to unsolved questions about mosquito-borne encephalitis — an infectious disease of the brain. Their unlikely searching points for the causative viruses are several sites throughout the state, including park areas and wooded lands.

While it is known that birds are a basic source of these viruses — and perhaps the primary reservoir — there are questions regarding the whereabouts of the viruses during the winter season when mosquitoes and the bird population in this latitude are at minimum levels.

Through one phase of the department's comprehensive project, blood samples are currently being taken from various species of Pennsylvania wildlife — birds, mammals and reptiles — for laboratory testing to determine

which animals may be harboring virus antibodies.

It is expected that various phases of the department's project will be carried out in several Pennsylvania counties this year including Adams, Berks, Cumberland, Dauphin, Erie, Lancaster, Lebanon, Mercer, Monroe, Montgomery, Pike, Union and York counties. Studies are also being conducted in Chester County, Allegheny County and Philadelphia County in cooperation with the respective county health departments.

The trapping and testing program, which has been carried on each summer since 1963, was recently expanded to a year-round program. The study is under the supervision of Dr. Ernest J. Witte, Chief of the Veterinary Public Health Section of the Division of Communicable Diseases.

Athletic Excellence, Safety Are Concern of Institute

The Pennsylvania State University has established a Sports Research Institute designed to bring together personnel from various fields to work with athletic departments. The purpose is to achieve excellence of athletic performance within the safest and best managed environment.

Sports research is not new at Penn State. For the past few years the biomechanics laboratory within the College of Health and Physical Education has developed sophisticated and scientific analysis of motion film sports performances. Film equipment and computer then have aided in the solution of some of the practical problems in sports.

A human performance research laboratory studies different types of equipment for physiological research with some interest in sports performances.

The primary emphasis of the research institute is to develop collabora-

tion between athletic and research personnel in an effort to find solutions to common problems.

Rutgers Survey Shows Pa.

Fourth In Alcoholics

Tranquilizers are now being used in the treatment of alcohol dependence. The major benefit of using such agents is that they provide relief from the anxiety, tension and depression that may precipitate alcohol abuse. A state-by-state analysis carried out by the Center of Alcohol Studies, Rutgers University, and supported by Sandoz Pharmaceuticals, revealed that Pennsylvania ranks fourth in the total number of alcoholics.

Sandoz is also providing any interested physicians with a series of recorded panel discussions with leading authorities on alcohol dependence and its treatment, and is currently preparing an Alcoholic Directory, as a state-by-state reference of treatment facilities and pertinent information.

State Control of Drug Prescription Blanks Urged

Following the death of two Pittsburgh teenagers who fatally took Dilaudid apparently obtained with altered or stolen prescription blanks, the Allegheny County coroner's office has asked the Pennsylvania Department of Health to consider proposals that would include specific prescription blanks serially numbered and printed in triplicate, for narcotics.

The proposal was made by Cyril H. Wecht, M.D., J.D., the Allegheny County coroner, and his chief toxicologist. The city has encountered a number of instances where individuals obtained drugs through forged, altered or stolen prescription blanks and he feels that steps should be taken to curtail the possibility of reoccurrences. To this end, he proposed that prescription blanks for narcotics should be issued only by the State Department of Health upon request from physicians and that the blanks contain a serial number and be printed in triplicate.

Dr. Wecht suggested that the physician be responsible for custody of these narcotic prescription blanks at all times and that the physician, after writing the narcotic prescription on the triplicate form, would keep one copy for his records and give the other two copies to the patient. The pharmacist, after receiving the two copies from the patient would retain one copy for his records and mail the third copy to the Department of Health for permanent filing. He further suggested that in writing narcotic prescriptions, physicians should use the same form used in writing a check—write out the quantity in longhand, followed by the number in Roman or Arabic form in parenthesis.

Dr. Wecht added: "We believe that the implementation of this system would greatly reduce the number of stolen, altered and forged narcotic prescription blanks throughout the state, and thus, hopefully avoid the tragic deaths that have been occurring with increasing frequency during the past few years." Dr. Wecht's recommendations will be considered by the PMS Board of Trustees at its next meeting.



"WHAT'S THE ANSWER, DOCTOR?" is an hour-long radio show which has been presented on radio station WHLM, Bloomsburg, for more than a year. Each program is on a medical subject of popular interest and the audience may call in questions on their particular problems. Randolph C. Blodgett, Jr., M.D., Danville, was moderator when the show was introduced. Frederick L. Jones, Jr., M.D., Danville, took over the lead spot a few months ago. Ray Calabrese, WHLM, is master of ceremonies. Airing the subject, "High Blood Pressure," on the July show are, around the table, Ray Calabrese; F.B. Clemens, M.D., Berwick; Dr. Jones; David A. Dayton, M.D. and William J. Kimber, M.D., Danville. The show is co-sponsored by the Montour County Medical Society and Columbia County Medical Society.

Hahnemann Granted Million Dollars To Develop Child Psychiatry Program

More than one million dollars has been granted to the Hahnemann Medical College and Hospital of Philadelphia to develop new community programs in child psychiatry, child mental health and mental retardation. Nearly 50,000 children in the area bordered by Montgomery Ave., Chestnut St., the Delaware River and the Schuylkill River, will be affected by the endeavors. The community has been cited in these grants, and in previous grants which created the Hahnemann Community Mental Health Center in 1967, as a "highest priority" community for mental health services.

The National Institute of Mental Health has granted \$868,972 to mount a community mental health program

for children and young adolescents. The program has the endorsement of Model Cities.

A second grant of \$191,000 has been made through the Pennsylvania Department of Welfare for a new community oriented mental retardation program.

Both projects are under the aegis of Hahnemann's Department of Psychiatry, Division of Child Psychiatry. They will strive to keep patients in the home community as much as possible, and to involve the families of all patients in their therapy. One of the major goals will be the detection of mental illness and mental retardation in the very early years rather than in the teens or later years.

Pittsburgh M.D. Named to Top VA Position

Francis C. Jackson, M.D., for eighteen years chief surgeon at the VA Hospital in Pittsburgh and a professor of surgery at the University of Pittsburgh, has been appointed director of surgical services for the Veterans Administration. He assumes his duties in Washington, D.C. about September 1st.

In his new position, Dr. Jackson will be responsible for the surgical activities at all of the 166 hospitals within the VA system which maintains



DR. JACKSON

a close alliance with the majority of American medical schools. He will be particularly concerned with staffing, training programs and research in surgery.

As a member of many local, state, and national organizations, Dr. Jackson's interests have included emergency medical services. A series of annual disaster drills in Pittsburgh and Western Pennsylvania known as "Prep Pitt" and later "Operation West Pa" were initiated through his efforts.

He is chairman of the PMS Commission on Emergency Medical Services and has served as chairman of the AMA Committee on Disaster Medical Care. He also has served as consultant to the U.S. Public Health Service and the Pennsylvania Department of Health.

Jefferson Hospital Opens Clinic To Study Overwhelming Pain

Patients with baffling or overwhelming pain are the prime interest of Thomas Jefferson University Hospital's new pain clinic, headed by J. Eugene Ruben, M.D., of the department of anesthesiology. The clinic includes physicians of many specialties who use the team approach to solve the desperate problem of pain in patients who are referred to the clinic by their own physicians.

In many patients the cause of the pain is known, Doctor Ruben says, but better methods for its control are devised by pooling the knowledge of many specialists. In other cases, the patient has been incapacitated by pain that is not explained by the disease he has. "These are particularly challenging," he said. "In one recent patient, we determined that the serious and baffling pain in his face and neck was not caused by a recurrence of cancer, but instead might be the result of poorly fitting dentures or chronic sinusitis. The pooled efforts of an oral surgeon, radiologist, otolaryngologist, anesthesiologist and internist are leading to effective treatment of this man."

"In another patient who had been bedridden for months with unbearable shoulder pain, we found that the pain was not caused by a recurrence of cancer, which was suspected. Instead the patient had a bronchial infection that needed more intensive treatment. The shoulder pain was managed by a muscle relaxant, a temporary nerve block, and a carefully chosen exercise program."

"This is our goal — getting people functional again, within the limits of their disease, by controlling the symptom of pain. Looking at it another way, you could say that the patients referred to us are ones in whom pain is so troublesome that it is almost the disease itself."

Doctor Ruben pointed out that chronic pain such as that produced by low back disorders and other reflex sympathetic dystrophies are a national health and economic problem that costs billions of dollars a year in lost work time. Recognizing this more than two years ago, the U. S. Department of Health, Education and Welfare urged

the development of centers like this for the treatment of chronic, intractable pain.

Another important contribution of the Pain Clinic is the opportunity it gives for physicians to learn more about the management of pain problems. As the average age of the population increases, these problems are bound to increase. "Knowledge we now have must be used more effectively," Doctor Ruben said, "and we must encourage physicians to do more research on pain."

Philadelphia Has Emergency Plan

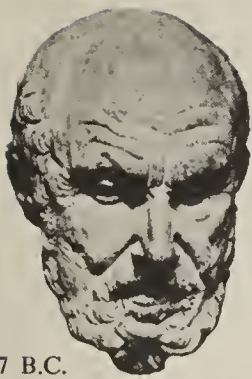
The Philadelphia County Medical Society has endorsed a plan to organize emergency medical care for the citizens of Philadelphia. Copies of the plan have been sent to Mayor James H. J. Tate and Paul D'Ortona, president of City Council, by Society President Jonathan E. Rhoads, M.D.

It proposes to develop a community-wide emergency health plan to improve the quality of daily emergency care. Among the recommendations suggested in this comprehensive report are the division of the city into seven parts, with five different types of health care facilities ranging from major emergency to long term care in each division. Another proposal is to turn Philadelphia General Hospital into an extended care facility for unfortunate victims injured beyond medical help (i.e., the victim of a severe head injury who has a live body but a nonfunctioning brain) and to build a new city hospital in north central Philadelphia.

The proposed plan is the result of six years of study and research. It was designed under the guidance and leadership of William F. Bouzarth, M.D., chairman of the society's emergency medical care committee.

Distinguished Society Announces New Name

The Pennsylvania Tuberculosis and Health Society recently announced a change in the society's name. It is now the Pennsylvania Tuberculosis and Respiratory Disease Association.



Hippocrates knew...

c. 460-377 B.C.
Father of Modern Medicine



Florence Nightingale knew...

1820-1910 A.D.
Light of Modern Nursing

What every Doctor and Nurse should know about Wine



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The time and place of wine's discovery by mankind are lost in the obscurity of perhaps a hundred centuries. It may have happened in pre-historic Persia; or perhaps on the slopes of Mt. Ararat, where, as the Old Testament tell us, Noah landed, and under his covenant from Yahweh was inspired to become a winegrower. And he enjoyed his wine, and as you know, Doctor, his years on this earth were nine hundred and fifty.

Physicians have been prescribing wine — as we know from records in ancient Canaan and Cairo — for at least 5,000 years. And the immortals of healing, too, knew the wisdom of wine in therapy — such gods and goddesses of health and healing as Imhotep of Egypt and Apollo of Greece and Rome; and Asclepius and his daughters Hygieia and Panacea in whose names the Oath of Hippocrates was sworn; not to mention such winewise immortals of science, hygiene, anatomy, medicine and patient care — born too late to be deified — as Moses, Hippocrates, Aristotle, Galen, Leonardo da Vinci, Fracastoro, Paracelsus, Vesalius,

Paré, Harvey, Jenner, Florence Nightingale, Pasteur, Lister, Osler.

All this time, wine has served man as a good food and source of vitamins, long before he knew or worried about vitamins; his most perfect natural beverage, next to milk; together with bread, his faithful daily companion at the table; with religion and music and philosophy, his solace and joy and symbol; with other spices and age-old herbs, his palate's delight; with friends, his pledge of fellowship and faith; in his declining years, his nurse and his milk, as both Galen and Osler taught; in strain and anxiety, his promise of tranquility; in convalescence, his aid to appetite and hope and cheerfulness; and in the gentle hands of an understanding nurse, his tender loving care.

And what is wine to you? In addition to offering aid to your success in your profession, is wine also a daily pleasure in your home, a subtle appetizer, a companion to your good cooking, good eating and good living, an unforgettable element in your hospitality to friends?

We hope that it is.

And in your work? Is wine, man's oldest and gentlest tranquilizer, aiding in care of your patients in the many types of cases wherein its effectiveness is constantly being proven, both empirically and by solid scientific research?

We hope that it is.

Is wine helping you to build and sustain morale, to reduce complaints — sometimes amazingly — in your pa-

tient's home, your hospital and nursing home, as it is doing in more and more care centers each month, all across the country?

We hope so.

For more than two hundred years, ever since Father Junipero Serra brought the first cuttings of the *vitis vinifera* grape to San Diego, July 16, 1769, we have been dedicated here in California to man's pleasure and good health, good eating and good fellowship. Perhaps you have visited our hospitable winelands.

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Good health and long life to your patients and to you, in the wisdom and well-being of wine.

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DEPARTMENT I-12 WINE ADVISORY BOARD, 717 MARKET STREET, SAN FRANCISCO, CALIFORNIA 94103



Harriet M. Harry, M.D., State College, was recently selected as the woman of the year by the Pennsylvania Federation of Business and Professional Women's Clubs. Dr. Harry, a charter member of the State College Business and Professional Women's Club, was nominated by that club on the basis of her outstanding professional activities, her energetic service to the community and her personal example which have brought honor to women in business and the professions.

A plaque commemorating the award was presented during the annual convention of the Pennsylvania federation in Philadelphia.

The 1970 Strittmatter Award was presented to **David A. Cooper, M.D.** A graduate of the University of Pennsylvania, he is widely recognized for his study of pulmonary disease. Dr. Cooper is emeritus professor of internal medicine at the Hospital of the University of Pennsylvania.

John T. Dickinson, M.D., and **Joseph A. Cipicic, M.D.**, Pittsburgh otolaryngologists were panelists for the sixth annual scientific meeting of the Facial Plastic and Reconstructive Surgery, Inc., held in Hollywood Beach, Fla.



Katherine R. Sturgis, M.D., internationally known authority on tuberculosis and lung cancer detection was the recipient of the 1970 Alumnae Achievement Award given annually by the alumnae association of Women's Medical College of Pennsylvania. Dr. Sturgis was the first woman to become president of the Philadelphia County Medical Society and is now professor emeritus at Women's Medical College. She is chief editor of "Archives of Environmental Health," and the only woman editor of a major medical journal in the United States.

Patrick S. Pasquariello, Jr., M.D., associate physician at The Children's Hospital of Philadelphia, recently received the annual award of the League of Children's Hospital. He was honored for his contributions to pediatric medicine.

Stanley M. K. Chung, M.D., has been named chief of the department of orthopedics at The Children's Hospital of Philadelphia. Dr. Chung is also associate professor in orthopedics at the Hospital of the University of Pennsylvania.

Marvin E. Haskin, M.D. has been named professor and chairman of the Department of Diagnostic Radiology, Hahnemann Medical College and Hospital of Philadelphia. Dr. Haskin has published extensively and is co-author of *Roentgenologic Diagnosis*.

T. Terry Hayashi, M.D., Pittsburgh, was named president-elect of the Society for Gynecology Investigation at its seventeenth annual meeting held in New Orleans in early April. The society consists of elected faculty members from medical schools in the U.S. and Canada who have made significant research contributions in the field of human reproduction.

Alfred M. Bongiovanni, M.D., physician-in-chief of The Children's Hospital of Philadelphia was recently elected to the American Association of Physicians. **C. Everett Koop, M.D.**, surgeon-in-chief at the hospital became president of the American Association of Pediatric Surgeons.

Edithe J. Levit, M.D., secretary and associate director of the National Board of Medical Examiners, recently received a citation given to outstanding Women's Medical College alumna by the Commonwealth Committee of the Women's Medical College of Pennsylvania.

Warren H. Fake, M.D., Ephrata, was honored as an outstanding physician and alumnus of the year by Hahnemann Medical School.

M. Louise Gloeckner, M.D. was honored at the annual dinner meeting of the Montgomery County Medical Society. Dr. Gloeckner is the first woman to serve as vice-president of the American Medical Association. She

has also been a president of the Montgomery County Medical Society and a vice-president of the Pennsylvania Medical Society.

Salvatore G. DeMarco, M.D., Easton, has received the American Medical Association's Physician's Recognition Award for his "pursuit of excellence in the profession of medicine." Dr. DeMarco is one of the first area physicians to receive this award.

L. Signorella, M.D. was re-elected president of the medical staff of Canonsburg General Hospital. Also re-elected were **M. C. Vallejo, M.D.**, as vice-president and **S. Safran, M.D.**, as secretary-treasurer.

Michael J. Aronica, M.D., chief medical officer at Allied Services for the Handicapped, Clarks Summit, was elected chairman of the northwest area wide committee, Greater Delaware Valley Regional Medical Program. He succeeds **David W. Kistler, M.D.** of Wilkes-Barre.

Thomas J. Rohner, M.D. has been named assistant professor of surgery in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University. He will continue his research in the study of energy-producing chemical reactions in the bladder muscle and with the influence of the nervous system controlling bladder contraction.

Charles Dick, M.D. and **Barbara Wojciehoski, M.D.** were presented with the Pennsylvania Hospital's 1970 Mathey Awards. The awards are granted for the best papers written during the academic year.

Six Philadelphia physicians, five specialists in internal medicine and a pathologist, have been honored by the American College of Physicians for their prominence and contributions to internal medicine. They are: **Henry L. Bockus, M.D.**, **Thomas M. Durant, M.D.**, **Richard A. Kern, M.D.**, **J. Grier Miller, M.D.**, and **Francis C. Wood, M.D.**, all internists; and **Esmond R. Long, M.D.**, pathologist.

The 1970-1971 officers of the Pennsylvania Society of Anesthesiologists, Inc., have been named. They are:

Frank J. Tornetta, M.D. of Norristown, president; **Harry Boretsky, M.D.**, Pittsburgh, president-elect; **Louis J. Hampton, M.D.** of Hanover, secretary and **William D. Stewart, M.D.** of Allison Park, treasurer.

Allen E. Yeakel, M.D. currently a professor of anesthesiology at the West Virginia University School of Medicine, has been appointed professor and chairman of anesthesiology in the College of Medicine at the Milton S. Hershey Medical Center of the Pennsylvania State University.

Walter J. Myslewski, M.D., Mount Pleasant, and **Benjamin S. Gillespie, M.D.**, Monroeville, have been appointed to the medical staff at the Henry Clay Frick Community Hospital.

Howard D. Jones, M.D. of Elizabethtown has been granted a \$1,000.00 award by the American Academy of General Practice. The award is to aid outstanding young physicians planning careers in general practice. He is a 1969 graduate of Hahnemann Medical College in Philadelphia.

Gordon Jones, M.D., Waynesburg, was presented with a Golden Key Award in recognition of his concern and services rendered to Greene County community in the areas of health and welfare.

J. Albert Eyler, M.D. of Bedford, was installed as president of the Pennsylvania Highlands Heart Association at the organization's annual meeting.

Dominick J. Raso, M.D., Easton, was recently elected president of the medical staff at the Muhlenberg Medical Center in Bethlehem. He succeeds **Eugene J. Kutty, M.D.**

Franklin S. Bizousky, M.D., Punxsutawney, has been named a diplomate to the American Board of Family Practitioners. Also receiving this certification are **Lester Sablosky, M.D.** of Jeffersonville and **Theodore Yarboro, M.D.**, Sharon. Dr. Yarboro was presented with a distinguished service award earlier this year by the Midwestern Pennsylvania Heart Association, of which he is immediate past president.

Robert S. Wedeen, M.D. was elected chief of staff of Coatesville Hospital during the annual medical staff meeting. In addition to his new position Dr.



A MEDICAL EXHIBIT titled, "Surgical Management of Frontal Sinus Disease," based on techniques used by Harry R. Morse, M.D., associates in the department of otolaryngology and bronchoesophagology at Geisinger Medical Center, Danville, won a certificate of merit at the recent American Medical Association convention held in Chicago.

Wedeer is also chief of the orthopedic service and is chairman of the department of surgery at the hospital.

Harvey Neidorff, M.D., chief of staff at Mercy Hospital, Altoona, was elected at the eleventh annual forum on allergy. Dr. Neidorff is the sixth recipient of the Von Pirquet Gold Medal for outstanding achievements in allergy research. He is a diplomate of the Board of Allergy and Immunology, and is president of the Middle Atlantic States of America Association of Clinical Immunology and Allergy.

Max M. Strumia, M.D., Bryn Mawr, was presented with a certificate of recognition for his fifty years of service in the practice of medicine. Dr. Strumia is president and director of the John S. Sharpe Research Foundation of the Bryn Mawr Hospital, and has received national acclaim for his work in blood and plasma. **Cecil W. Hancox, M.D.** of Pottstown also received an award for his fifty years in practice at the Montgomery County Medical Society's annual dinner.

John J. Bennett, M.D., was elected president of the medical staff of Harrisburg Hospital. Dr. Bennett succeeds **Herbert V. Jordan, M.D.** He is an associate in the American Academy of General Practice.

David B. Schaffer, M.D., associate ophthalmologist at the Children's Hospital of Philadelphia, was appointed assistant professor of ophthalmology at the University of Pennsylvania School of Medicine.

Cyril H. Wecht, M.D., Allegheny County Coroner, was re-elected to the position of president of the American College of Legal Medicine at its annual meeting. Dr. Wecht is also research professor of law and director of the Institute of Forensic Sciences at Duquesne University.

The Philadelphia Allergy Society elected the following officers for the year 1970-1971: President — **Howard E. Sullivan, Jr., M.D.**; vice-president — **Burton Zweiman, M.D.** and secretary-treasurer — **Peter E. Siegler, M.D.**

Leonard D. Policoff, M.D., formerly professor and chairman, Department of Physical Rehabilitation, Temple University Health Center, has been named professor and chairman, Department of Physical Medicine and Rehabilitation, Hahnemann Medical College and Hospital of Philadelphia. Dr. Policoff has served as medical director of Moss Rehabilitation Center and director of physical medicine at Albert Einstein Medical Center.



Tribute to Eugene P. Pendergrass

Having Gene Pendergrass on your side is like having another complete team. Once he has espoused your cause, his devotion is constant, his energies are unflagging and the degree of his concern is endless.

Dr. Pendergrass has served our state medical journal for many years—considerably longer than the medical editor. He has been a contributing editor for more years than most, if not all, of his present colleagues on that board. During these years there has been a steady stream of suggestions, contributions, introductions to new ideas and new methods sent to us by Dr. Pendergrass from all parts of the United States and frequently from foreign countries. Not only does he make suggestions for betterment, secure contributions not otherwise obtainable and make many other offerings to the staff but he does this, year after year, with no diminution of interest or decrease in motivation.

Perhaps even more outstanding is his willingness to put himself to any inconvenience and labor to help carry out any project of PENNSYLVANIA MEDICINE in which we have sought his help. Within hours, one can secure action, and his support is not only full and free but is practically always effective.

While your editorial staff has enjoyed these years of support, it is clear that this is only a small part of his contribution to medical affairs. I have had only a partial chance to observe his work in the field of radiology, and this is a remarkable example of modern practice of his specialty. The most elegant practice of radiologic medicine, a steady, high-level program of research in radiology, superior teaching of resident physicians and other radiologic personnel as well as medical students, and an active part in the continuing medical education of practicing physicians would be a full life's work in itself. Dr. Pendergrass' name may also be found on the cover of *The American Journal of Roentgenology*, *Radium Therapy* and

Nuclear Medicine, indicating a further activity in medical education. When he retired to emeritus status, he had provided an admirable staff to take over this outstanding department under the command of Dr. Richard Chamberlain.

But this is not the whole story. Dr. Pendergrass also managed to be active in the several radiological societies of this and other countries and to partake in a wide assortment of symposia on many medical subjects.

In spite of all these instances, his involvement is deep so that the result is highly productive for the project in hand. What is unique about Gene Pendergrass is that he makes each such occasion an opportunity for cross fertilization. If he takes part in an international meeting on silicosis, all of his medical interests are likely to benefit. Certainly, PENNSYLVANIA MEDICINE could expect to receive one or more communications from the meeting with resulting scientific advantages.

Not the least impressive of Gene's multilateral efforts, has been his work for organized medicine. His work as delegate to the AMA for the Section on Radiology offered a fine field for his exceptional talents and his seemingly limitless energy. Not only did he strongly support radiology in the House of Delegates and in work in the Section of Radiology, but he was always active in the general activities of the delegates. At the meeting of our Pennsylvania delegations he could be counted on for well-considered opinions and judicious political activity.

It is obvious that this writer's view is an incomplete one. But this only serves to strengthen the thesis of this writing: Eugene P. Pendergrass is a remarkable man with an astonishing breadth of medical interests. He is a great physician. His teaching makes him more worthy than most of us to be called doctor. He is highly deserving to be honored by his fellow practitioners of his state. CBL

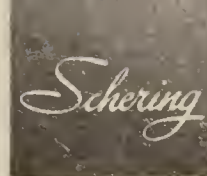
Gestational Hormones and Sarcoidosis

A case report in this issue (page 37) succinctly reports the occurrence of sarcoidosis in a young lady who had been taking Enovid® for several years. This coincidence seems worthy of the practitioner's attention because of the need to unravel the tangle of etiologic questions about sarcoidosis.

The author of the case report, Dr. Rose L. Tse, carefully points out that there is no implication of a causal connection in the coincidence. It is, however, a fact that

florid sarcoidosis often improves during pregnancy and that an explanation for this finding could be expected to be valuable.

It is highly likely that the joint occurrence of sarcoidosis and administration of Enovid® will be seen by many physicians in the future. Since we are much in need of more information about the role of hormones on the course of sarcoidosis, such case reports are greatly to be desired and their publication is to be encouraged. CBL



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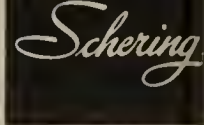


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*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Erie and Harrisburg is 207,000.
(Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	Less Severe 0.8-1.2 mg./kg. for 7-10 days	Resistant/ Moderately Severe Larger doses or additional antibac- terial therapy should be consid- ered in severe urinary tract infec- tions or in resistant cases involving the renal parenchyma or anatomic anomaly.	Serious/Life- Threatening
Other Infections including bacter- emia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		up to 5 mg./kg.

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

**IN VITRO INHIBITION OF CLINICALLY IMPORTANT
BACTERIA BY GENTAMICIN SULFATE
(TUBE DILUTION STUDIES)**

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by:				No. of <i>In Vitro</i> Studies
		4 mcg./cc. or less	8 mcg./cc. or less*	16 mcg./cc. or less*	32 mcg./cc. or less*	
<i>Staphylococcus aureus</i>	1,210	1,200 (99%)	1,206 (99%)	1,206 (99%)	1,206 (99%)	11
<i>Pseudomonas aeruginosa</i>	885	771 (87%)	828 (93%)	828 (93%)	828 (93%)	16
<i>Escherichia coli</i>	836	736 (88%)	779 (93%)	779 (93%)	779 (93%)	11
Indole-positive and indole-negative <i>Proteus</i> species	477	210 (44%)	358 (75%)	358 (75%)	358 (75%)	12
<i>Klebsiella-Aerobacter</i> species	292	205 (70%)	231 (79%)	231 (79%)	231 (79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa*, 828 (93%); *Escherichia coli*, 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.

Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa*, *Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg. (¾ gr.) 48.6 mg.	

(Warning: may be habit forming)

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.



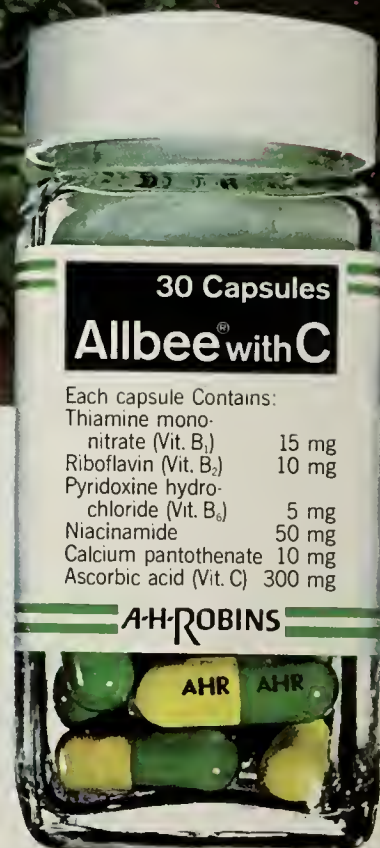
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AMA and Its Critics

About half-way through the recent AMA Convention in Chicago, I was approached by a medical writer from one of the newspapers. He showed me the copy he was about to file. "I tried" he said "to find something favorable to write today. I really did. Every time they have an opportunity to do something good for people it seems as though they let me down." He was talking about the House of Delegates, of course. I read what he had written and I pointed out some of the things which, I felt, showed evidence of social consciousness. "Oh yes," he said, "but they should have done so much more."

I said to him, "You are applying greyhound expectations to a tortoise organization." I am sure this did not satisfy him.

One of the advantages of maturity, (I refuse to call it aging) is that you recognize how much time there is and how unimportant "hurry" is. As a matter of fact, the AMA has been moving forward by leaps and bounds over the last several years. Here we have an organization of well established, successful men who are, in most cases, beholden to no one except themselves, who have concerned themselves with the public good ever since the organization was founded. The AMA has never acted to put money in the pockets of individual doctors. Scientific standards and requirements have consistently been established and maintained. Vigorous campaigns for better health care and against quacks and dangerous nostrums have protected the public long before government got into the act.

Social concerns have tended to move more slowly, but this is because this is a conservative organization, comfortable with the status quo. Delegates need to be convinced that changes recommended are for the real betterment of the situation in question. Nevertheless, this is the organization that once opposed health insurance and now is its greatest supporter; that fought tooth and nail against government medical care for the aged, and yet today has accepted Medicare and has been largely responsible for its successes. This is the organization that within three short years has gone from a policy of abortion as a crime to an almost complete approval of the operation as a matter solely between the doctor and the patient.

The newspapers criticized AMA handling of the radical actionists at this last meeting. I wonder what other organization would have suffered outsiders to break into its deliberations and violently introduce extraneous material. Would this have been permitted by a Masonic body? How would it have been received by the AFL-CIO? As any private organization has every right to do, the AMA defended its legislative proceedings and carried them out in a dignified manner. The AMA went further than it needed to by permitting these organizations a rostrum and offering an opportunity for their problems to be heard.

Youth is impatient. Having plenty of time, it cannot

wait to take deliberate thought. If a structure shows an imperfection it wants to tear it down and build afresh. The fact that the new building will have twenty errors that need fixing to one in the original is glossed over. The lesson of history which is human experience takes time to learn.

The gifts of youth are clear vision, energy, and enthusiasm, qualities less plentiful on the further side of the gap. Age tends to be complacent about low standards and repeated mistakes, but it knows the inefficiency of precipitous action. Somehow youth and experience must mix and form an amalgum active enough to clean out impurities and yet stable enough not to explode. The stable AMA is becoming more active all the time.

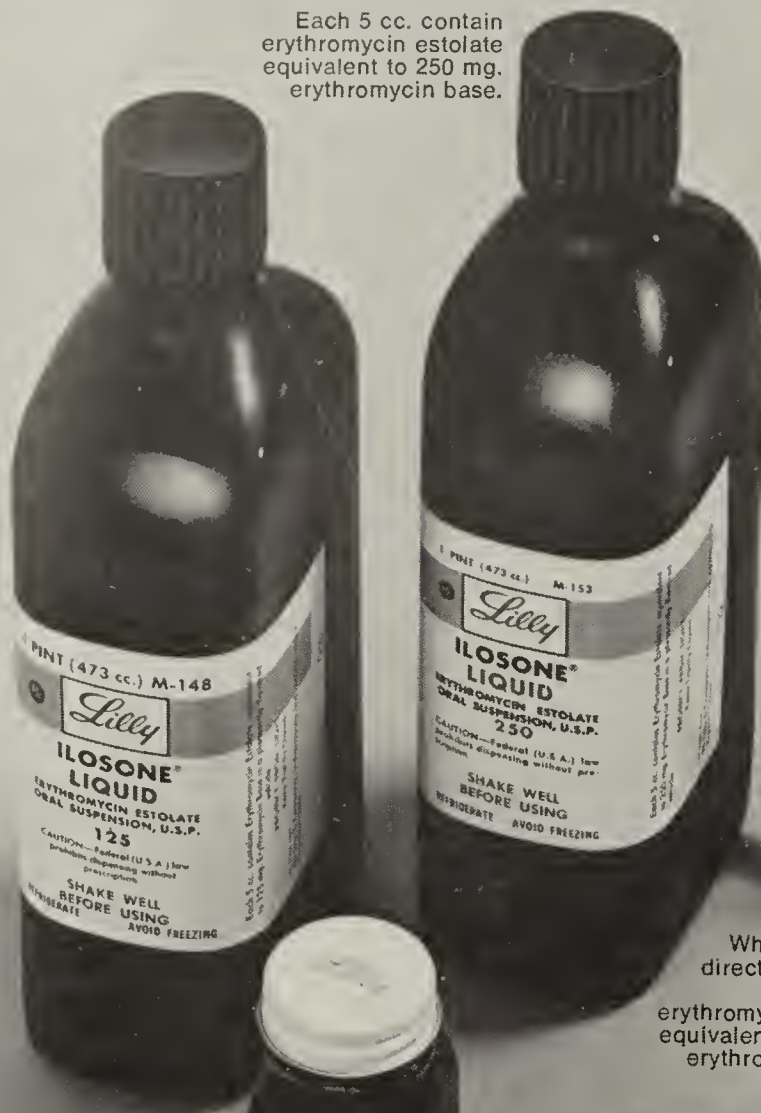
No physician need apologize for this high purposed society which is no labor union. Every doctor should recognize the debt he owes his association and welcome the opportunity to pay dues. When doctors ask "What does the AMA do for me?" I say "You owe the favorable climate of your scientific and professional life to this organization. Like the air you breathe it is unnoticed but everywhere necessary. Were there no AMA the medical climate would be medieval and chaotic. If, by neglect, you let it die, the quality of American medicine and all of our way of life will be diminished."

George A. Rowland, M.D.
Millville

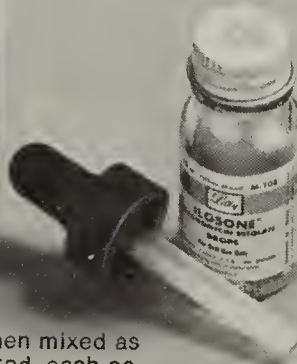
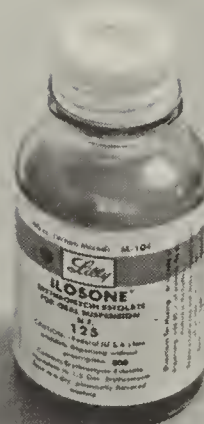


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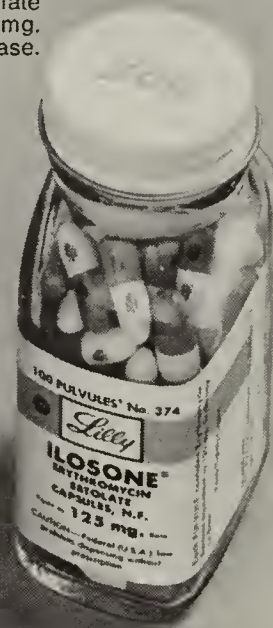
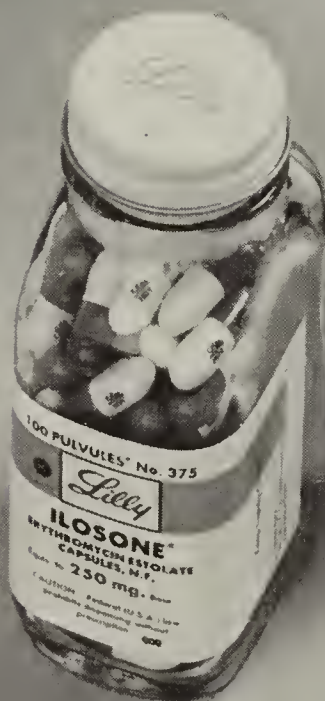
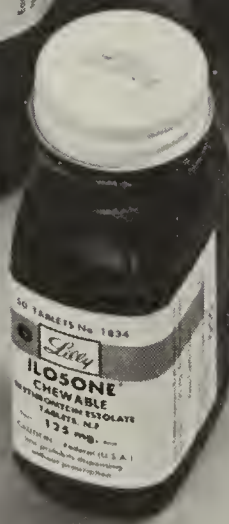
When mixed as directed,
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Sarcoidosis in a Patient on Oral Contraceptive Therapy

ROSE L. TSE, Ph.D., M.D.
Bala Cynwyd

In view of the current widespread use of progestin-estrogen combination drugs as oral contraceptives, it is the purpose of this report to describe the clinical course of a case of sarcoidosis in a patient on such hormonal therapy. No causal relationship between the medication and the disease is implied.

The role of gestational hormones on the course of sarcoidosis is uncertain although the effect of pregnancy on sarcoidosis, and vice versa, have been studied (1, 2, 3, 4). Most investigators agree that pregnancy is not affected by sarcoidosis nor does it reactivate the healed disease. Florid sarcoidosis, particularly pulmonary involvement, often improves during pregnancy only to relapse after delivery. The explanation for this finding is not well understood. Elevated plasma corticosteroid level during pregnancy could conceivably be, in part, responsible for such improvement.

Case Report

C.W., a twenty-eight year-old healthy white female began to take Enovid® in the fall of 1964. She remained in excellent health until December 22, 1966 when she developed vague substernal discomfort and right pleuritic chest pain, diagnosed and treated by another physician as "pleurisy". No chest x-ray was taken at that time. Her symptoms disappeared after 2 weeks.

On 1-27-67 she was seen by the author because of pain in her left knee attributed to a fall sustained several days earlier. Pertinent findings in-

cluded a 2-cm. diameter localized pleural friction rub at the right lung base, minimal swelling and tenderness of the medial aspect of the left knee, no calf tenderness and no lymphadenopathy. Chest x-ray showed bilateral lobular hilar masses, a small streak of infiltration in the left 3rd anterior interspace and at the right costophrenic sulcus. Intermediate strength PPD skin test was strongly positive, measuring 25x25x3 mm. at forty-eight hours. On 2-2-67 she was admitted to the hospital for study. Complete blood count and differential, blood urea nitrogen, two hr. postprandial blood sugar, urinalysis, heterophile titer, serum protein electrophoresis, calcium, phosphorus, alkaline phosphatase, transaminases, electrocardiogram, x-ray studies of the hands and feet, slit lamp examination of the eyes and spirogram were within normal limits. Sputum culture showed normal flora and smear was negative for acid fast bacilli. A right scalene fat pad biopsy (5) yielded several enlarged

Dr. Tse is senior attending physician in the department of medicine of the University of Pennsylvania Division of Philadelphia General Hospital. A graduate of the Medical College of Pennsylvania (formerly Woman's Medical College), she also has a Ph. D. in organic chemistry. Dr. Tse wishes to express her gratitude to Harold L. Israel, M.D., who saw the patient in consultation and concurred with the diagnosis of sarcoidosis. Elsie R. Carrington, M.D., encouraged the author in the preparation of this manuscript.

lymphnodes, the largest one being 1 1/2 cm. in diameter. Histological examination of the nodes revealed non-caseating, non-confluent granulomas composed entirely of epithelioid cells consistent with sarcoidosis. The patient was discharged on 2-11-67, completely asymptomatic, with the instruction to take isoniazid 300 mg. daily for one year. Sputum and lymphnode cultures for acid fast bacilli reported six weeks later were negative.

Follow-up chest x-ray at two to three month intervals showed disappearance of the peripheral infiltrates on 3-28-67, slight decrease in hilar adenopathy on 7-25-67 and complete regression on 1-25-68. Throughout this time the patient has remained asymptomatic and has continued taking Enovid®.

Discussion

It is general knowledge that most patients with sarcoidosis have tuberculin anergy. In this case, considering the totally benign course, the negative cultures for acid fast bacilli, and the finding of non-caseating granulomas on lymphnode biopsy, it was felt that the diagnosis of sarcoidosis was justified in spite of the unusual feature of a strongly positive tuberculin reaction. Since tuberculosis may develop in a sarcoid patient with positive tuberculin reaction (6), isoniazid was administered prophylactically.

Enovid®* certainly did not adversely affect the sarcoidosis. Whether

* G. D. Searle and Co.

or not it had favorably influenced the regression of the pulmonary lesions remains an open question and cannot be answered on the basis of this one single case. Furthermore, the fact that the patient did recover completely and rapidly while continuing the Enovid® therapy would tend to dispel any causal relationship in this case between the drug and sarcoidosis, a

disease of unknown etiology.

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Contribution of Private Mental Hospitals to the Commonwealth

In these days when hospitals of all kinds are under fire from almost anybody who makes a speech or has an ax to grind, it is particularly disconcerting when private hospitals come under even more concentrated fire from the sniping laity than do hospitals in the public sector. This is especially true of mental hospitals, perhaps more so than general hospitals.

It is well known that the general public is not acquainted with the facts, but how many physicians are aware of the valuable role that private mental hospitals play in the mental health of our citizens, and the great public service that is done in this Commonwealth and the other states?

To be specific and to cite a few figures, three private psychiatric hospitals in Southeastern Pennsylvania: Fairmount Farm, Friends, and the Institute of the Pennsylvania Hospital were compared with Haverford State Hospital, Norristown State Hospital, and the Philadelphia State Hospital. The statistics for last year are indeed interesting.

1969	Beds	Admis- sions	Re- leases
Public			
Haverford State Hospital	670	1202	1212
Norristown State Hospital	2729	990	1229
Philadelphia State Hospital	3600	1800	1600
	6999	3992	4041
Private			
Fairmount Farm	132	1057	1066
Friends	190	1046	1042
Institute of the Pennsylvania Hospital	254	1218	1232
	576	3321	3340

It is noteworthy that the state hospitals had a bed capacity slightly more than twelve times the three private hospitals, yet the admissions of the three private hospitals are just 671 less. If one would project into the private sector the same number of available beds, he would find that the private hospitals would predictively have had 39,852 admissions. They are accepting from the community ten times the number of patients and theoretically doing ten times the work, therefore, of the public hospitals with the same capacity.

There are many factors which might modify these statistics somewhat. Please be assured that these figures are presented just for the purpose of drawing to your attention the great public service performed by the private mental hospital. Of course, what is indicated also is that not only do private hospitals, with far fewer beds available, receive almost as many patients as public hospitals having twelve times their capacity, but also the patients are treated and discharged in a much more rapid fashion, thus providing an even greater service to the individual patient and to the community.

William W. Wilson, M.D.
President and Medical Director
Fairmount Farm

"The Commission on Mental Health/Mental Retardation continues to invite for publication, pertinent articles on psychiatric and mental health subjects."

Paul J. Poinsard, M.D.
Chairman
Commission on Mental Health/
Mental Retardation

The New Professional Corporation Law What Should Existing Medical Associations Do ?

LEIF C. BECK*
Bala Cynwyd

Pennsylvania's new Professional Corporation Law (the "PCL"), which became effective on August 8, is already the subject of many articles and lectures. Most of these discussions stress how the new law materially improves the advantages in a previously unincorporated physician's taking the corporate leap.** This article will instead briefly summarize the law's significance for physicians who are already in corporate form, those who are "employees" of their own professional associations.

An existing professional association should consider the PCL as a call for two important actions. First, since the law provides simple means of bringing existing associations under its new and favorable rules the opportunity to obtain coverage should by all means be taken. Second, but equally important,

the association's consulting its attorneys and advisors on obtaining the new coverage presents an ideal opportunity to assure that the important but too often overlooked corporate details have in fact been properly handled. Since the Internal Revenue Service is now attaching great significance to these details, the physician should welcome his own advisor's review.

Obtaining PCL Coverage

It is most important for a physician to bring his old professional association under new PCL in order to improve the Internal Revenue Service treatment of his venture. Both of Pennsylvania's old association acts have been poorly treated by the IRS. In its ruling (Revenue Ruling 70-101), summarizing its attitude towards the various states' statutes, the IRS included neither the 1874 Act nor the 1961 Act among its list of those laws under which properly formed organizations would be accorded corporate tax treatment. The new PCL, however, is patterned after state laws which have been accepted by the IRS. Thus it is virtually certain that coverage under the new law will cause the organization to be accepted, at least initially, as a corporation for tax purposes. The opportunity to take advantage of such an improvement should obviously not be ignored.

Those physicians practicing under the old Professional Partnership Act of 1874, available if there were three or more associates, *automatically* became covered by the PCL on the August 8 effective date. There is no legal requirement that these physicians take any specific steps to obtain new professional corporation status. Section 4(d) of the PCL provides, however, an opportunity for the converted organization to file a new document with the Department of State in Harrisburg to register itself as a professional corporation and also to obtain from that department a certificate establishing its new status. Although these steps are optional and perhaps do no more than confirm the automatic PCL coverage, it is strongly suggested that the old 1874 Act groups take advantage of this opportunity to prove their corporate characteristics.

Physicians practicing instead under the Professional Association Act of 1961, the only previous corporate choice for one and two man groups, are permitted to come under the PCL by filing with the Department of State a very simple election certificate. This certificate, to be signed by each shareholder-associate, should state the association's name and address, the county in which its original articles of association were filed and a statement that the shareholder-associates have elected to accept the PCL's provisions. Upon

*The author was a partner of Pepper, Hamilton and Scheetz, attorneys, Philadelphia, Pa. until September 1. His office is now located in Bala Cynwyd, Pa.

**The present tax and business outlook on incorporation, plus a general description of the then proposed Professional Corporation Law, was presented by Mr. Beck in Pennsylvania Medicine, May, 1970, Vol. 73, pp. 54-58.

the filing of this certificate, the 1961 Act association will be "deemed to be incorporated." As it does for 1874 Act associations, Section 4(d) of the PCL affords the converted 1961 Act association an opportunity to file a new corporate document with and obtain corporate certification from the Department of State. These latter steps are optional, but they will undoubtedly be worth the slight cost and effort.

In almost every case, the single motivating reason behind incorporation was the desire for tax benefits. Now that the PCL has provided an opportunity to improve the likelihood of such tax benefits, the physician would be remiss to let it pass.

Checklist of Commonly Ignored Operating Details

If an Internal Revenue Service agent should question an association covered under the PCL, he will probably concede that the organization may as a matter of *law* be treated as a corporation. He may nevertheless analyze very critically whether the physicians are actually complying with those details which prove the *fact* of corporate status. In effect, though the agent may concede that the corporation was *organized* satisfactorily he will question whether it is being *operated* properly. This emphasizes attention to detail, including continuing help of attorneys, accountants and consultants, to assure that the properly launched corporation has not run adrift.

A number of existing professional associations have failed to comply with what should be no more than minimal corporate details. Whether because the physician-owners have not been sufficiently advised or because they have ignored the advice, the deficiencies should be remedied promptly. The present call to take advantage of the new PCL presents this as a convenient time to check for these deficiencies. Although by no means intended to be a complete checklist, the following matters should obviously have been taken care of. Nevertheless, this writer has observed one or more of them overlooked far too often.

1. Are the patient billings actually being rendered in the name of the association? One should recognize that

upon incorporation medical treatment is being rendered by the association through its physician-employees, not by the physicians on behalf of themselves. Their actions should conform to this principle.

2. Has the physician's Blue Shield account been assigned into the association's name? Blue Shield has a specific procedure for adoption of such an "Assignment Account," thus recognizing the corporate status.

3. Has the State Board of Medical Education and Licensure approved the practice of medicine under the corporate name? Such approval is required by the board, which will act only after receiving favorable recommendations of both the Pennsylvania Medical Society and the county medical society in which the association's major office is situated. The state board also requires a biennial registration of the organization with payment of a \$25 fee each year.

4. If a physician has been added or removed from the association, have the proper notifications been given? Both the Blue Shield rules and the state board regulations require prompt notice upon any change of medical personnel.

5. Have formal employment agreements between each physician and the association been properly executed? Although such agreements may seem mere legal make-work, many court decisions upholding the professional corporation recited their existence. If the courts consider them significant, it would at least be prudent to use them.

6. Have leases for medical office space been assigned from the physician's own name (or the name of the predecessor partnership) to that of the professional association? Once again, the practice is now the association's practice and the facts should support this premise.

7. Have all of the utility accounts, including telephone listings, been transferred into the corporate name? These simple steps are important to confirm the more obvious lease transfer discussed above.

8. Similarly, has all appropriate insurance coverage been amended to

include the association as an insured? Perhaps the most important policy change involves the malpractice insurance under which the association should be added to the coverage, but the physician himself should obviously not be removed. The addition should not involve any extra premium, but it certainly helps substantiate the "corporate" medical practice.

9. If the medical practice involves significant pieces of equipment, has the transfer of this equipment to the association been properly documented? Similarly, if the physician's business automobile was to become corporate property has the auto registration actually been changed? Although the auto transfer involves a 6 per cent sales tax on the car's value, the tax cost should be accepted if the transfer is considered useful from a tax standpoint.

10. If the owner-physicians had originally elected to have their association taxed under "Subchapter S", have they considered when that election should be revoked? Subchapter S status has in many cases provided protection against certain potential tax problems, but for corporate tax years beginning on and after January 1, 1971 the status will cause drastic reduction of retirement plan contributions. The election may be terminated by the filing of a properly signed revocation only within a prescribed time period, and the matter should thus be considered presently to prevent unintentional loss of the pension and/or profit sharing plan tax advantages.

The foregoing list should demonstrate that incorporation involves far more than the simple execution and filing of a few legal papers. If the answers to these questions can be answered affirmatively, and if continued attention is given to corporate details, there should be far less reason to fear an Internal Revenue Service examination. Since the PCL really calls for a new look at the association's existing legal documents and certification, this is an ideal time to make sure the various operational details have been and will continue to be up to good "corporate" standards.

PMS Testimony on Medicare and Medicaid

MATTHEW MARSHALL, JR., M.D.

I am Matthew Marshall, Jr., M.D., of Pittsburgh, the chairman of the Pennsylvania Medical Society's Council on Medical Service and I appear here today as its representative to describe our efforts to make Medicare and Medicaid as efficient as possible and to present recommendations for improvements. I am in the private practice of urology and I have been deeply involved in working with third parties, especially in the utilization and review area, for more than twelve years.

Immediately following the passage of Medicare, the Pennsylvania Medical Society sponsored, along with the State Office of Medicare, a series of seminars across the state to familiarize physicians and their office assistants with the new program. Since that time, we have maintained close liaison with the state agency, the Social Security Administration Bureau of Health Insurance, Blue Shield, the Blue Cross Plans, and the Travelers Insurance Company.

It is obvious that there were and continue to be problems but I am sure that our joint efforts in Pennsylvania have minimized them. For example, the implementation of the Medicare Program with its many inherent complexities made it necessary for the Bureau of Health Insurance and the fiscal intermediaries and carriers to recruit and train many additional — and inexperienced — employees. In view of this tremendous "tooling up", we feel that the performance of the carriers and intermediaries in Pennsylvania and the Bureau of Health Insurance has been relatively commendable.

'... it is important to clarify the substantive differences between claims review programs and utilization review programs.'

The goals of peer review activities have been the subject of considerable discussion recently. There have been references that failure of utilization committees to control costs has been a major reason for increased hospital costs. We will describe briefly some of our experiences, dating back to 1958, in developing various peer review mechanisms. In this discussion, it is important to clarify the substantive differences between "claims review programs", which are often misnamed "utilization review programs", and "hospital utilization review programs". In a "claims review" activity, the focus is on an individual case whereas with

"hospital utilization review" the goal concerns the total pattern of admissions, stays and procedures of an institution.

The motivation and methodology of committees of physicians engaged in claims review is quite different than those involved in utilization review. In claims review, the committee is concerned with the appropriate administration of health benefits. In utilization review, the goal is the most appropriate use of institutional facilities. In claims review, the cost affect is immediate. In utilization review, health care costs are affected only after the period of time that is required for the committee recommendations to be considered and approved or rejected as part of the factors in determining the future nature and scope of services an institution may offer.

Both claims review and utilization review are important, but to assume they are identical leads to confusion. Such confusion apparently existed at the time the Medicare Law was developed, but this is understandable since both concepts were relatively new at that time.

'The PMS believes all residents are entitled to quality medical care...'

Many of the current judgments that hospital utilization committees are performing poorly arises from a lack of understanding of their function within the law. They have not achieved the state of perfection but specific guidelines hardly can be written to assure perfection. However, progress under Medicare in developing meaningful utilization committees has been much faster than the progress, if any, made by the Veterans Administration — a totally federally controlled and regulated comprehensive multi-specialty group practice health plan. Improved performance can be obtained by providing guidance with latitude to motivate utilization committee members, hospital administrators, fiscal intermediaries and agencies, such as the Hospital Utilization Project, to work together to meet this challenge of more effective use of the health care dollars. The Pennsylvania Medical Society has established claims review programs, in cooperation with Pennsylvania Blue Shield, for Part B, Medicare beneficiaries; and with Blue Cross and Travelers Insurance Company for hospital and extended care benefits. In conjunction with the Hospital Council and Blue Cross, we established the Hospital

Utilization Project (HUP) to assist hospital utilization committees in performing their basic functions. Our joint efforts also resulted in much progress in encouraging utilization committee development. (See "The Hospital Utilization Project" by Paul M. Lewis, M.D., in the March, 1970 issue of PENNSYLVANIA MEDICINE.)

The Pennsylvania Medical Society will continue to work with all persons and agencies concerned in the development of a better Medicaid Program. To date, the program in Pennsylvania has been understaffed and underfunded and it depends upon the willingness of physicians to perform services at or below their overhead costs at a 1948 fee schedule, or without any charge in order to avoid the paperwork involved. We have recommended that Blue Cross and Blue Shield underwrite the entire Medicaid Program. This would be a major step in removing the so-called "medical assistance" stigma, by making each recipient a card-carrying Blue Cross-Blue Shield subscriber on a basis comparable with five million other such subscribers in the state. We also have recommended greater flexibility so that the program might deal more effectively with those urban and rural areas where there are large concentrations of eligible recipients.

The Pennsylvania Medical Society, believing that all of our residents are entitled to quality medical care, believes that legislation is required to assure that all employed persons have a voluntary health care plan that is at least equal to existing Blue Cross and Blue Shield Plans. We support the AMA Mediredit Plan as a means of accomplishing this objective. We believe the needy should have a plan that allows them to compete effectively with more affluent citizens in obtaining needed health care services. For that reason, we have supported a prevailing fee plan for Medicaid but it has never been implemented. Apparently the more affluent majority of citizens will not support sufficient tax revenues to achieve this objective so that today most of the needy in Pennsylvania continue to be dependent upon the charitable intention of physicians and other health care providers.

I stress that subsidization by physicians currently is required for the Medicaid Program to be operable in Pennsylvania. Failure of the legislature and the public to recognize this present state of affairs impedes the development of the maximum cooperative effort required if we are to achieve the goals of better health care for the needy.

Obviously, a major purpose of this hearing is to find ways by which the cost experience of the Medicare Program can be changed by reducing the inflationary trends of health and medical care costs. Medicare obviously helped resolve problems of enrollment, underwriting and individual costs for the aged, but it has proven to be both costly and frustrating for patients and their relatives and for physicians and other providers of health care, as well as intermediaries.

I believe that the basic defect in the Medicare Law is that it is oriented to the provider to carry out the specifics as determined by Congress. Apparently it was designed primarily on the advice of a relatively few "expert" providers of medical care and "experts" in the theory and administration of the delivery of health care rather than upon the documented variety of demand as perceived by

consumers of health care. In the final analysis, it is difficult to deny the public what it wants in the matter of priorities for health care expenditures. Provider concepts of necessary medical care, medically unnecessary custodial care, or even misuse, need public acceptance and understanding to be appropriately applied. Experts can appropriately help the public in understanding health care needs and can suggest areas for health care expenditure efficiencies. However, their cost projections can and have been wrong and their ability to define what is appropriate or inappropriate medical care for the public has differed from the public demand. As an example, there is the prediction that extended care facilities could be a significantly less costly alternative to hospital care, or that the distinction between medical care and custodial care in extended care facilities could be made to assure the proper use of such facilities.

'There are limitations to the effectiveness of regulations. . .'

Real incentive for better cost controls and planned effectiveness seems to depend upon a more consumer-oriented plan where the consumer would have a choice of intermediaries, each of whom would be given latitude to organize and underwrite the plan to meet the beneficiaries' demand for the services they feel they need at the lowest possible cost. The result would be a competition among the intermediaries for potential enrollees, a competition that holds the greatest incentive to achieve utilization and cost goals. This is a change recommended by the Pennsylvania Medical Society and it is similar to one recommended by Dr. Victor Fuchs, Ph.D., vice president of Research for the National Bureau of Economic Research.

It is hoped that the Senate will recognize that there are limitations to the effectiveness of regulations and that regulations increase both costs and the demand on manpower necessary in physicians' offices to implement them. In the attached memorandum to Mr. Wolkstein of the Bureau of Health Insurance, I have set forth a number of areas where I believe that Blue Shield of Pennsylvania could be encouraged to experiment in ways to increase the cost effectiveness of their plan. Yet Congressional action appears to be more in the direction of shifting the cost to the patient by increasing the percentage of physicians' fees the patient will have to pay by lowering the allowable "percentile" in Part B payment calculations.

Your staff has indicated that the key to making the present system workable and acceptable is the physician and his medical society. This highly complicated "lock" appropriately awaits the "key" in the person of the busy physician. Despite the billions of dollars in Medicare monies, it is significant that the solution is said to rest in physicians giving extra, unpaid time to increase the effectiveness of health care financing systems. I believe that this may well be a correct — though somewhat paradoxical — assumption. The progress that we have made with Blue Cross, Blue Shield, and government officials most often has resulted from the "extra unpaid efforts" of physicians, often during the "off" hours of these officials.

Thank you for allowing me the privilege of appearing here today.



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- Gradual onset of action avoids the danger⁴ of sudden electrolyte and fluid depletion.
- May be effective as the sole diuretic or may be combined with a thiazide, furosemide⁵ or ethacrynic acid⁶.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone, particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops.

Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may

potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For essential hypertension in adults the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or effusions in adults initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; sup-

plemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For children the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Dall, J. L. C.: *Amer. Heart J.* 70:572-574 (Oct.) 1965. 2. Liddle, G. W.: *Ann. New York Acad. Sci.* 139:466-470 (Nov.) 1966. 3. Gontt, C. L.: *Diuretic Therapy*, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. 4. Alexander, S.: *Geriatrics* 23:131-139 (Nov.) 1968. 5. Stason, W. B., and others: *Circulation* 34:910-920 (Nov.) 1966. 6. Lieberman, F. L., and Reynolds, T. B.: *Gastroenterology* 49:531-538 (Nov.) 1965.

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Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warning: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children re-

duce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.



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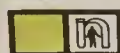
☐ Accidental Trauma ☐ Postoperative Tissue Reactions. Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.



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Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

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PENNSYLVANIA MEDICAL SOCIETY
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SUMMARY

1970 REPORTS

PENNSYLVANIA MEDICAL SOCIETY

All items appearing in this special section of PENNSYLVANIA MEDICINE are summaries of the 1969-1970 annual reports. Complete annual reports, including the Auditor's Report, appear in the booklet, *Official Reports to the House of Delegates*, copies of which are available upon request.

BOARD OF TRUSTEES AND COUNCILORS

Park M. Horton, M.D.

This report summarizes significant actions taken by the Board of Trustees during the 1969-70 year, as outlined in the Board's Annual Report.

The Board:

Determined to increase the number of Councilor District meetings in order to increase membership understanding of the Society's programs as well as to provide individual members with an opportunity to impact upon the shape and design of programs and policies by using such meetings as a forum to voice suggestions and criticism.

Established the Interspecialty Committee to make readily available to the officers, Board of Trustees and House of Delegates the knowledge, wisdom, facilities and energy of the medical specialty societies in Pennsylvania. It was also the hope of the Board that such a committee would facilitate access of medical specialists to the policy making aims of the Society and also improve coordination of professional effort in the community.

Created a Lay Advisory Committee to provide a medium for dialogue between concerned public leaders and members of the medical profession about health care problems in Pennsylvania.

Approved a series of long-range objectives proposed for the Society which were developed by the Committee on Objectives. For the specifics, see the Annual Report of the Committee on Objectives.

Approved in principle and referred favorably to the House a recommendation of the Council on Education and Science that the Society should not entertain thoughts of supporting periodic relicensure at this time but should require all of its members to qualify for the AMA Physician Recognition Award in order to retain membership in the Pennsylvania Medical Society and that each component

county medical society be urged to establish the same requirement for its members.

Reviewed thoroughly the major sections of the report of the AMA Committee on Planning and Development (Himler Report) and instructed the AMA Delegation to support the positions adopted by the Board before the appropriate reference committees at the June, 1970 meeting of the AMA House of Delegates. See the Annual Report of the Board of Trustees for an outline of the Board's position with regard to the major recommendations contained in the report of the Committee.

Determined that the Pennsylvania Medical Society continue as the grantee for the Susquehanna Valley Regional Medical Program for an indefinite period of time, subject to annual review.

Determined to investigate all the factors involved in the establishment of and ultimate promotion of a satellite office and "registered physician assistant" concept, with careful consideration being given to the terminology used in such a program.

Instructed the AMA Delegation to introduce into the AMA House of Delegates a resolution regarding AMA membership for allied professions personnel and support of the concept of Flexnerizing the allied professions training programs.

Authorized the Chairman of the Board to appoint a committee to meet with members of the State Board of Medical Education and Licensure for the purpose of reviewing the Medical Practice Act and suggesting appropriate revisions.

Authorized the Pennsylvania Delegation to the AMA to introduce and support at the June session of the AMA House of Delegates a resolution calling for the AMA to develop, produce and place on a nationwide network a continuing series of public affairs television programs, beginning with balanced presentations on the socioeconomics of health care.

This year I have become acquainted with the many aspects of the secretary's office. I have administered the medical defense fund, and participated in the work of the Committee on Medical Benevolence. In the course of signing official documents I have noted a growing number of our members seeking to form professional associations; fourteen being approved by the State Board in 1969 and one additional to May 15, 1970.

The secretary's office has referred numerous grievances to county societies and in cooperation with legal counsel, has provided legal opinions to members and component societies. It has been a pleasure and a privilege to attend Board meetings.

JUDICIAL COUNCIL

Resolution 68-13: Fee for Service

In 1969 the House reconsidered Resolution 68-13: "Fee for Service," and amended the "Resolved" portion as recommended by the Judicial Council. The amended Resolve reads:

"**RESOLVED**, That the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical, or surgical service unless the physician personally provides or personally supervises the service rendered."

This action of the House was brought to the attention of the council for its information and future reference.

Amended Resolution 68-17: Computer Systems

In 1969, at the recommendation of the Board, the House adopted an amended version of Resolution 68-17. As amended, the Resolved portions read:

"**RESOLVED**, That the Pennsylvania Medical Society seek the results of the studies being conducted by the American Medical Association on computer technology, with particular reference to privileged communications and the use of medical data stored by non-medical agencies; and be it further

"**RESOLVED**, That these materials be considered by the appropriate council or committee with a view to recommending appropriate action to the Board of Trustees and House of Delegates."

On October 31, 1969, the Chairman of the Board referred this resolution to the Judicial Council through a letter addressed to Council Chairman Lewis T. Buckman, M.D., which said in part:

"Since this matter deals largely with the question of access to privileged communications, I believe the Judicial Council is the appropriate unit to seek the results of the studies conducted by the American Medical Association and to determine whether or not these studies provide legal and ethical guidelines which could be promulgated among the membership. If the studies do not answer these needs, we would look to

the Judicial Council, with the assistance of legal counsel, for recommendation as to what steps should be taken by the Board of Trustees. Since the problem of the use of medical information by computerized data collection agencies is nationwide in scope, I would presume that the council's recommendations would likely involve recommendations for action by the American Medical Association.

"The Board of Trustees will look forward to a report from the Judicial Council concerning this matter."

Sincerely,

Park M. Horton, M.D., Chairman
Board of Trustees

The Council has communicated with the AMA regarding the ethical and legal problems associated with the storage of patient records in computers; it has also conducted its own research. The complete report of the Council on this matter is found in *Official Reports to the House of Delegates*.

Resolution 68-25: Discrimination

The 1969 House also received a report from the Judicial Council regarding Resolution 68-25, "Discrimination," which called upon the AMA to clarify the term "repeated violations" as it applied to medical associations which deny membership to applicants because of creed, race, religion or ethnic origin. The House concurred with the report of the Judicial Council which advised that implementation of anti-discrimination clauses of the AMA Bylaws by the AMA Judicial Council constituted a reasonable response by the AMA to the intent of the PMS sponsored resolution. The council notes the support of the House in this matter and pledges to keep it apprised of significant developments therein.

Resolution 69-6:

Special Hospital Funds

The Council noted the indefinite postponement by the House of Resolution 69-6, "Special Hospital Funds," the resolved portion of which would have called upon the AMA House of Delegates to adopt the guidelines of the PMS Judicial Council as they pertain to special hospital funds derived from fees for medical treatment.

Resolution 69-19:

Reaffirmation of "Sole Arbitrator" Position

Resolution 69-19 "Reaffirmation of 'Sole Arbitrator' Position," adopted by the 1969 House of Delegates, expresses disagreement with the Judicial Council's interpretation of the American Medical Association guidelines as they pertain to the right of the physician to be the 'sole arbitrator' of the disposition of his professional income and requests the Council to reconsider such opinion. The Resolved portion of this resolution states:

“RESOLVED, That the House of Delegates, Pennsylvania Medical Society, reaffirms Resolution No. 67-14; and be it further

“RESOLVED, That the House of Delegates of the Pennsylvania Medical Society disagrees with the Judicial Council’s interpretation of the American Medical Association guidelines as they pertain to the right of the individual physician to be the ‘sole arbiter’ of the disposition of his professional income; and be it further

“RESOLVED, That the House of Delegates, Pennsylvania Medical Society, strongly recommends that the Judicial Council reconsider its interpretation of these guidelines and issue its opinion at the earliest possible date.”

On February 4, 1970, Lewis T. Buckman, M.D., chairman of the Judicial Council, wrote to Park M. Horton, M.D., chairman of the Board of Trustees, reporting the disposition of Resolution 69-19 by the Council.

On March 11, 1970, the Board of Trustees accepted Dr. Buckman’s letter as information and voted unanimously to include it in the Board’s annual report.

MEDICAL DEFENSE

During 1969, five applications for medical defense were filed and approved. During the same period, three medical

defense cases were closed. The total expenditure for legal fees from the Medical Defense Fund in 1969 was \$12,716, leaving a balance of \$106,883 in the fund. For further comments on the fund’s status, see the Report of the Treasurer.

In 1967, at the request of the Delaware County Medical Society, the Society undertook the medical defense of the Delaware County Society in a malpractice suit brought by the Rev. Arthur N. Thompson of Colwyn. The plaintiff charged that he had contracted polio in connection with a county society sponsored Sabin oral polio vaccination program. In December 1969, the case was closed before going to trial; the State Society provided legal defense for members in Delaware County to the amount of \$5,520.00.

As of May 31, 1970, there were forty-four active medical defense cases in our files. By councilor districts these are as follows:

First:	8	Seventh:	1
Second:	16	Eighth:	0
Third:	2	Ninth:	0
Fourth:	2	Tenth:	11
Fifth:	2	Eleventh:	1
Sixth:	0	Twelfth:	1

In twenty of the cases listed above, the physicians do not carry malpractice insurance.

EXECUTIVE DIRECTOR John F. Rineman

This report summarizes significant points contained in the Annual Report of the Executive Director:

Actions taken by the 1969 House of Delegates have, at this stage, either been fully implemented or are now in the process of completion.

A management conference of key members of the staff was held at a location away from the distractions of the office for the purpose of getting these key people to focus on administrative problems and to develop long-range goals. Several ideas were developed dealing with methods of improving interstaff communications as well as communications with the membership.

Last year three new members were added to the staff for the Susquehanna Valley Regional Medical Program, bringing the figure to twenty-one employees. The financial burden for this part of the Society’s operation is borne entirely by the Federal Government including the salaries of the staff assigned to the program. Although the Society’s programs and projects have burgeoned, careful management of its human resources and use of modern equipment such as computers have made it possible so far for the Society to avoid an increase in that portion of the staff whose salaries are paid directly out of Society funds.

During the early part of this year, members of the staff of the Regional Medical Programs Service of the Department of Health, Education and Welfare, and a site visit team, made up of persons involved in other Regions and the

National Committee, met with the Regional Medical Program staff, the grantee and key members of the voluntary groups. The site visit team members, in particular, were most complimentary concerning the staff and the general progress of the Program in the Region.

Pennsylvania Medicine’s advertising income the first seven months of 1970 showed about a one-fourth drop from the same period last year and it is impossible to predict the advertising future. Readership surveys have indicated that *Pennsylvania Medicine* is being read by an increasing number of the members and it is our goal to have the magazine become a part of the reading pattern of each physician member in the state.

1970 dues statements for fifty-eight (58) county medical societies were prepared by Electronic Data Associates, the Society’s computer service bureau. Figures for 1968-69 show a decrease of one hundred forty-three (143) in the number of full dues paying active members but an overall increase of thirty-three (33) active members, dues paying and dues exempt.

The building continues to serve as the principal location of most Society meetings including the Board of Trustees, councils, commissions and committees. Several specialty societies and health related organizations have also used the Society’s headquarters for meetings. The invitation to county societies to hold a meeting at the headquarters building is always open.

The customary examination of the Society's accounts as of December 31, 1969, was performed by Main, Lafrentz & Co., Certified Public Accountants, and the report of their audit is being submitted to all members of the House of Delegates. It is available to others upon request.

The Society's resources are contained in five separate funds. Four of these funds are earmarked for special purposes and are not available for current operating expenses.

The annual assessment of our members who pay full dues was \$75 for the year 1969. Of this total, however, only \$66 was available to the General Fund for the operating expenses of the Society. By action of the House of Delegates, \$9 per member was allocated as follows: \$8.00 to the Educational and Scientific Trust for loans and scholarships and \$1.00 to the Medical Benevolence Fund.

The General Fund is the active functioning account for the day-to-day operation of the Society's various programs. During 1969, income for this account (derived chiefly from dues, advertising in PENNSYLVANIA MEDICINE, commercial exhibits and registration fees at the scientific session, and investments) amounted to \$968,265. Expenses for 1969 totaled \$838,045. With income of \$968,265 and expenditures of \$838,045, the Society ended the year with a surplus of \$130,220 in the General Fund.

The Medical Defense Fund had assets totaling \$107,938 at the beginning of the fiscal year. The allotment from dues paid late in 1968 amounted to \$24, income on investments totaled \$5,593, and the Fund realized a gain of \$6,459 on the sale of investments. The Fund paid out \$12,716 for medical defense purposes and \$415 for investment expense for a total of \$13,131, which resulted in a loss of \$1,055

for the year, thus decreasing the assets of the Fund to \$106,833 as of December 31, 1969.

Assets in the Medical Benevolence Fund totaled \$547,614 on January 1, 1969. The Fund received \$10,844 from dues allocations and \$27,301 from income on investments. Contributions from the Woman's Auxiliary amounted to \$8,276. Gain on the sale of investments of \$8,866 brought total income to the Fund of \$55,287. Payments to recipients of \$40,911 and investment expense of \$1,851 left a net balance of \$12,525 for the year. This brought the total assets of the Medical Benevolence Fund to \$560,139 as of December 31, 1969.

At the beginning of 1969, the Contingency Reserve Fund was valued at \$119,142. The Board of Trustees authorized the transfer of \$75,000 from the 1968 surplus to the Contingency Reserve Fund. Income on investments was \$7,335. A gain on the sale of investments amounted to \$21 and investment expenses totaled \$421. These transactions resulted in an increase in the assets of the Fund to a total of \$201,077 on December 31, 1969. An additional transfer of \$121,295 from the 1969 surplus to the Contingency Reserve Fund was authorized by the Board of Trustees on March 11, 1970.

As of December 31, 1969, the Property and Equipment Fund included land and building valued at \$745,048 and furniture and equipment valued at \$69,395. Reserves for replacement of both the building and the furniture and equipment accounted for \$83,338. The mortgage was reduced to \$89,687 by the end of 1969. The total value of the Property and Equipment Fund at the close of the 1969 fiscal year was \$897,781.

SUMMARY REPORTS OF INDIVIDUAL COUNCILORS

FIRST DISTRICT

A. Reynolds Crane, M.D.

The Philadelphia County Medical Society, which comprises the First Councilor District, has again been fortunate in the foresight and dedication of the two presidents whose terms overlap the period of this report. Theodore H. Mendell, M.D., and Jonathan E. Rhoads, M.D., have been especially discerning in identifying significant problems and adept in enlisting the support of persons most able to deal with them. Both have been impressively effective spokesmen of positions developed by the society and their joint efforts have reflected credit upon the society.

In Philadelphia with its medical schools and numerous teaching hospitals, the problem of Medicare payments and

reimbursement for teaching activities as well as reimbursement for care of assigned patients has been a particularly thorny problem. A committee appointed by Dr. Mendell and chaired by Dr. Rhoads prepared a policy statement which earned the concurrence of the deans and which was published in *Philadelphia Medicine* (65:17:751-753, September 5, 1969). It has been adopted by a number of other counties and can be recommended to any group which is concerned with the problem.

The society maintains some fifty-eight standing and special committees, the activity of which varies greatly

from group to group and year to year but there is a consistent productivity from the deliberations.

Notable again this year was the activity of the Committee on Medical Economics under J.D. Alexander, Jr., M.D., and the search by its Subcommittee on Malpractice Affairs under R. Robert Tyson, M.D., for an answer to the pressing problem of the availability and increasing cost of malpractice coverage, through liaison with the committee of the State Society and the special committee appointed by the insurance commissioner. A well attended and stimulating symposium on the subject was held under the auspices of the committee.

The Emergency Medical Care Committee under William F. Bouzarth, M.D., has continued its pattern of preparedness. To cope with a threatened closure of emergency services by some hospitals because of failure of financial support by government, his committee organized volunteer physicians and allied health workers to staff a disaster hospital of 200 beds which did not have to be activated.

The society membership program has continued its explorations of means of encouraging all physicians to accept their responsibilities for the health of the community through participation in the activities of the Society which now has 2,859 regular members, 233 associate members and 440 affiliate members. For his untiring and productive efforts in this area, David S. Cristol, M.D., deserves great credit. Membership has been opened to osteopathic physicians and means of involving interns and residents in the activities of the society are being explored. In line with the action of the State Society to add medical student delegates to the House of Delegates, the county society through Hugh D. Bennett, M.D., and his Committee on Student Affairs, is arranging for students to attend committee and branch society meetings.

Grouped under a Committee on Public Health and Mental Studies, chaired by Robert D. Harwick, M.D., are activities concerned with alcoholism and drug dependence, blood banking, cancer control, air pollution, mental health, medical hypnosis, pre-school and school health, to mention but a few areas of concern for the health of the community that have been selflessly pursued by the members.

The educational activities of the society, for its members and the community, continue to face the challenge of finding effective means to enable both to use and benefit by the most modern advances in medicine. The society, with the assistance of the Pfahler Foundation, will support one preceptorship under the program of the American Academy of General Practice. The Post Graduate Institute, under Charles R. Shuman, M.D., and Stanley H. Lorber, M.D., will return to center city after an exploration of the advantage (or non-advantage) of motel facilities in the outskirts and with a new format of conferences and workshops. The Greater Philadelphia Health Fair, again organized so ably by Malcolm W. Miller, M.D., attracted 81,000 visitors in six days and during that period conducted some 35,000 health tests to detect 500 abnormalities and effectively educate the public through demonstration. In a similar vein, through the society free blood sugars were performed at some thirty hospitals during Diabetic Detection Week.

Members of the society were given special recognition

during this year. David A. Cooper, M.D., long a member of the House of Delegates and distinguished for his work in diseases of the chest as well as for his humanism, received the Strittmatter Award, the highest award of the county society. Henry L. Bockus, M.D., the renowned gastroenterologist, was presented with the Distinguished Service Award of the AMA. Special recognition and awards were given to M. Louise C. Gloeckner, M.D., on her election as vice-president of the AMA and to Anna M. Brady, M.D., in recognition of her position as the highest ranking woman physician in the U.S. Army.

The society presented the Benjamin Rush Award to Mr. Donald Cook in recognition of his activities in the health of residents of ghetto areas and to Horizon House for its activities in the rehabilitation of psychiatric patients. These latter awards call to mind that the physicians in Philadelphia have been playing a most active role in the efforts to improve the distribution of health care through such activities as the OEO centers conducted under the auspices of Pennsylvania Hospital in South Philadelphia and Temple University in the northeast. Hahnemann Hospital has sponsored a community center in the Spring Garden Street area and the St. Agnes Hospital staff has developed a health mobile program for their community. These programs have sparked a very cogent integrating effort by the Committee on Community Medicine under Pascal F. Lucchesi, M.D., and P.B. Storey, M.D.

An activity of this district of which everyone is proud is that of the Benevolence Committee of the Aid Association of the Philadelphia County Medical Society. A report of this activity appears in *Philadelphia Medicine* for March 5, 1970 and as you read it and see the concern of the physician for his less fortunate colleagues and their dependents, your faith in the basic goodness of men will be affirmed at the cost of a tear in your eye.

The woman's auxiliary, under Mrs. J. Antrim Crellin and Mrs. Peter A. Herbut, has again contributed greatly to our activities. Their annual Health Institute held on April 1, 1970 attracted 200 persons. The ladies have again sponsored nursing scholarships to the number of four at the Philadelphia General Hospital.

The source of this report, *Philadelphia Medicine*, so well edited and structured by Donald C. Geist, M.D., details the happenings in Philadelphia in each issue. One year ago Mr. Richard Nelson succeeded "Bill" Irwin as executive director. Despite the obvious great difficulty in filling the shoes of a person so well respected and loved, Mr. Nelson has earned his own niche by his organization of his tasks and his prompt execution of his duties. During this year the first district lost through death a number of its outstanding members, including Edward L. Bortz, M.D., Moses Behrend, M.D., J. Parsons Schaeffer, M.D., Joseph Scarano, M.D., William Gash, M.D., and others. To these men for their great contributions to medicine we pay tribute.

These few comments very briefly touch upon a host of activities. Many very productive efforts have not even been mentioned but the PMS will be well aware of these as the agenda of the House of Delegates unfolds and the First District joins with its eleven brothers to discuss and formulate the most efficient methods of rendering health care to the citizens of Pennsylvania.

SECOND DISTRICT *Leroy A. Gehris, M.D.*

It is with a deep feeling of gratitude that I say "Thank you" to the leaders and members of the six county medical societies of the Second Councilor District for their acceptance of me as councilor to complete the unexpired term of William A. Limberger, M.D., president-elect of the Pennsylvania Medical Society. My association with the various physician groups has been a great and rewarding experience to me.

The first seven months of my tenure as councilor have been devoted to travel, having attended two meetings of each of the six societies as well as several executive board meetings and annual meetings.

A meeting of the Second Councilor District was held on June 6, 1970, at the Brookside Country Club in Lehigh County. Among those attending were William A. Limberger, M.D., president-elect of the State Society; John Rineman, executive director of the State Society; Dane Wert, executive assistant to the Council on Public Service; Robert Craig, executive assistant to the Council on Governmental Relations and Larry Fosselman, executive assistant to the Council on Medical Service. Topics discussed included: the Blue Shield Participating Doctor Agreement, problems associated with extended care facilities, public relations, drug abuse and malpractice insurance problems.

BERKS COUNTY

On December 9, 1969 David N. Farber, M.D., succeeded Irvin G. Shaffer, M.D., to become the ninety-first president of the Berks County Medical Society. At the same time John E. German, M.D., became president-elect and George P. Desjardins, M.D., was elected to the position of chairman of the Executive Council. Edward A. Agnew, M.D., is secretary; James F. Welsh, M.D., assistant secretary and Charles N. Wang, M.D., is treasurer.

Under a plan suggested by Dr. Farber, increased attendance was achieved at the April meeting. The plan is as follows: Scientific meetings are reduced to four per year planned to fall on the same evening as the regular compulsory staff meetings of the three community hospitals. The hospital staffs are invited to hold their meetings in the facilities of the county medical society just prior to the county medical society meeting. A prominent speaker is obtained for the county society meeting. The first meeting under this plan occurred on April 14, 1970 when the principal speaker was Ernest B. Howard, M.D., executive vice-president of the American Medical Association. More than 200 members attended, the largest Berks County Medical Society meeting in the past twenty years.

The Berks County Medical Society participates in a medical education program through presentation of videotape programs in a physician's home via his television set. This is made possible through the Berks TV Cable Corporation. This service, "Community Medical Cable Casting" is assisted by Roche Laboratories.

The society plans a rubella immunization program which

will be offered to every child in the eligible age group and not just those living in an area of 40,000 inhabitants or more.

A series of three public seminars on heart disease were presented in Medical Hall. A Diabetes Detection Clinic was offered to the public under the supervision of John R. Spanuth, M.D. Liaison was established with the Easter Seal Society for Crippled Children and Adults of Berks County. A request for cooperation from the Economic Opportunity Council and Model Cities Agency was answered with the appointment of Leon Reidenberg, M.D. to that organization. The Berks County Medical Society participates in the East Central Pennsylvania Area Wide Committee for Regional Medical Programs and Comprehensive Health Planning.

This report would not be complete without mentioning the fact that the Woman's Auxiliary of Berks County is proud of the accomplishments of one of their number, "Becky" Gehris, who is serving this year as president-elect of the Woman's Auxiliary of the Pennsylvania Medical Society.

BUCKS COUNTY

The main thrust of ongoing Bucks County Medical Society activities during the past year has been in the area of drug abuse. A special committee headed by Stanley F. Peters, M.D., has been working many long hard hours presenting movies, lectures, seminars and debates throughout the county in an effort to educate youth and adults alike.

At the December meeting, the following officers were elected: President, ChiuLing Chai, M.D.; Vice-President, John D. Lane, M.D. and Secretary Treasurer, Joseph T. Ichter, M.D.

In February it was reported that the county had been effectively immunized against an outbreak of rubella. The highly successful immunization project covered well over 50,000 children.

The March meeting was a joint medical-legal dinner. The program of the evening was reserved entirely for a debate and question-answer period on drug abuse and the pros and cons of liberalizing laws controlling their use and sale. The debate included Bernard Segal, esquire, of Philadelphia, a well-known exponent of liberalization and Richard Atkins, esquire, also of the Philadelphia Bar Association.

In April the society approved the required endorsement of the recently organized Bucks County Chapter — Pennsylvania Association of Medical Assistants.

An outstanding program on drug abuse was prepared jointly by a special committee of the Bucks County Medical Society and the Bucks County Bar Association for presentation on a county-wide basis in high schools. The program was utilized on Law Day, May 1, 1970, in ten of fourteen school districts throughout Bucks County. The committee

reported outstanding interest and acceptance on the part of students in most schools.

CHESTER COUNTY

The Chester County Medical Society is proud of its own William A. Limberger, M.D. who is serving this year as president-elect of the Pennsylvania Medical Society and is due to be elevated to the presidency of the State Society at its meeting in October of this year. This high honor has not been bestowed upon a Chester County physician since 1929 when William T. Sharpless, M.D., was president.

On Wednesday, January 21, 1970 at the Phoenixville Country Club, Michael B. Dooley, M.D., was elevated to the presidency of the Chester County Medical Society. Other officers installed included President-Elect, I.M. Waggoner, M.D.; Vice-President, Stephen M. Hanson, M.D.; Treasurer, William J. Barry, M.D. and Secretary, Donald E. Harrop, M.D.

One of the most active committees of the Chester County Medical Society is the Committee on Addictive Diseases, chaired by Donald N. Twaddell, M.D. It conducted speaker seminars in order to have speakers available to meet the requests from different groups throughout the county. A tape interview was recorded on the "drug problem" for broadcast by West Chester's radio station, WCHE. Dr. Twaddell and his committee spoke to numerous groups throughout the county either individually or as members of a panel.

Talks were given to junior high school groups in West Chester, Phoenixville, Coatesville and Downingtown. Committee members participated in a graduate school panel discussion for teachers at West Chester State College as well as at in-service meetings for teachers of the Downingtown School District, the Coatesville Area Schools Guidance Counselors and a meeting of all the district school superintendents of the county. The committee has also assisted the Council on Addictive Diseases (COAD) in setting up four county-wide public seminars on drug abuse.

The Council on Addictive Diseases maintains a twenty-four hour telephone answering service to facilitate referrals on drug problems. The council also has a paid staff which is involved in advice and counsel to young people. The committee is preparing a pamphlet to be sent to all society members on emergency treatment of patients suffering from an overdose of an addictive drug.

The county society participates in the activities of the appropriate comprehensive health planning agency. Copies of a report of the Chester County Personal Health Services Task Force done under the Comprehensive Health Planning Advisory Committee have been distributed to members of the Chester County Society.

Chester County also maintains an active medical scholarship program. The present recipient, Michael Bakkum of Oxford, Pennsylvania, was recently granted a \$500 per year scholarship for his four year medical school career. The county society is now supporting a total of four medical scholarships in all of the four years in the medical school program.

DELAWARE COUNTY

On Saturday evening, January 17, 1970 at the Alpine Inn, after a delicious dinner, the president's gavel was transferred from J. Vernon Ellson, M.D., of Upper Darby to Conrad A. Etzel, M.D., of Wallingford. Other officers for the new year included John H. Wigton, M.D., Swarthmore, president-elect; Otto F. Muller, M.D., Darby, vice-president; Hunter S. Neal, M.D., Media, secretary and Phillip J. Esagro, M.D., Springfield, treasurer.

One of the most important items of interest involving the Delaware County Medical Society occurred in this year. It concerned the settlement of the 1963 Poliomyelitis vaccine case. In this regard an individual who received an immunizing dose of Sabin Vaccine during the 1963 mass immunization program developed poliomyelitis. The suit was settled for \$35,000 in favor of the plaintiff. The Delaware County Medical Society was dismissed from the action without participating in the settlement. The pharmaceutical company involved and a health fund created with proceeds accumulated from the polio drive made the settlement.

On March 19, 1970 at a regular meeting of the Delaware County Medical Society the Pennsylvania Medical Society's 1969 Occupational Health Award was presented to the Boeing Company, Vertol Division of Delaware County.

John L. Kelly, M.D., chairman, Commission on Public Relations, secured a grant of approximately \$1200 from the society to purchase copies of the booklets "300 Most Abused Drugs" and "Drug Abuse: The Chemical Cop-Out" for distribution to members of the society, Delaware County police chiefs, health officers, members of the Delaware County School Administrators Association and the Delaware County Nurses Association.

At the regular meeting held May 21, 1970 Dr. Etzel, president, presented the 1970 Benjamin Rush Awards. The group award went to Mr. Charles E. Meyers, president of Camp Sunshine which has provided free camping experiences for more than 7000 disadvantaged youngsters over the past thirty-eight years. The individual award was presented to Mr. Benjamin Greenbaum, a pharmacist, who in 1962 founded the Rare Blood Group of the Llanerch Fire Company and Ambulance Service.

Robert F. Plotkin, M.D., has been appointed by Dr. Etzel to serve on the Regional Task Force on Personal Health Services and represents just an example of the society's involvement in Comprehensive Health Planning.

LEHIGH COUNTY

The inaugural banquet of the Lehigh County Medical Society was held on Saturday, January 17, 1970 at the Holiday Inn, Allentown. The presidential oath of office was administered to William F. Boucher, M.D., by Secretary Frank J. DiLeo, M.D. At this meeting a representative of INTRAV, a travel agency which arranges tours enjoyed by members of the society to various parts of the world, presented a check for \$2000 to the county medical society to be included in the Lehigh County Medical Society

Scholarship Fund. This makes a total in excess of \$7500 that has been presented to the scholarship fund by this travel agency since September 1968.

An interesting committee organized by the Lehigh County Medical Society is one that started out as a committee against health fraud and has developed into an incorporated body. This idea, originating in the Lehigh County Medical Society Board, has now become the Lehigh Valley Committee Against Health Fraud, Inc., with Stephen J. Barrett, M.D., as chairman. Members of the committee include physicians, clergymen, lawyers, dentists and osteopaths. The committee meets at least once a month and considers ways and means of legally combating health frauds occurring in the county.

At a meeting of the Lehigh County Medical Society Board on May 5, 1970, Jack A. Young, M.D., president, East Central Pennsylvania Area Wide Committee, Greater Delaware Valley Regional Medical Program for Regional Medical Programs and Comprehensive Health Planning requested that the society (one of six comprising the East Central Pennsylvania Area) cooperatively sponsor an executive director. He made the request so that the area might show good faith in securing a 314 B Planning Grant. Following his presentation and after a lengthy discussion, it was the unanimous decision of the board that the Lehigh County Medical Society pledge \$3000 a year for the first two years towards the operating costs of Comprehensive Health Planning.

MONTGOMERY COUNTY

At the November meeting Charles S. Amidon, M.D., of Pottstown was installed as president of the Montgomery County Medical Society. Other officers include President-Elect Byron Clyman, M.D., Norristown; Vice-President Michael D. McGuire, M.D., Norristown; Recording Secretary Ulysses E. Watson, M.D., Philadelphia and Treasurer Joseph L. Hunsberger, M.D., Norristown.

On March 4, 1970 a regular meeting of the Montgomery County Medical Society was held at society headquarters, 1529 DeKalb Street, Norristown at which M. Louise C. Gloeckner, M.D., past vice-president of AMA gave a report on recent programs of the American Medical Association. John L. Steigerwalt, M.D., a member of the Montgomery County Medical Society and vice-chairman of the Executive Committee of the Comprehensive Health Planning Advisory

Committee for South Eastern Pennsylvania spoke on comprehensive health planning.

At the May membership meeting President Amidon announced that the Commission on Forensic Medicine under Alan L. Dorian, M.D., had been meeting once a month and at times twice a month with representatives of the county bar association. He stated that the commission had requested permission to press toward a medical evaluation panel. This permission was given by the board and at such time as the mechanism is formalized it will be brought before the society for action. At the June 3, 1970, dinner meeting the society entertained judges from the Montgomery County Court.

Second Councilor District Physicians' Advisory Committee

The Second Councilor District Physicians' Advisory Committee met on Wednesday, March 25, 1970 and reviewed sixteen disputed Blue Cross cases, two Aetna cases and one from Metropolitan Life. It also made the following recommendations to the Second Councilor District Review Committee:

That the Second Councilor District Review Committee establish a policy of inviting all physicians who have cases before the committee (including osteopaths) to attend the meeting to present their viewpoints.

That the Second Councilor District Review Committee make it possible for county medical societies within the Second Councilor District to organize their own review committees to handle disputed fee cases and further, if a county medical society elects not to establish such a committee, disputed fee cases will be handled as they have been in the past.

That the Second Councilor District Review Committee evaluate the present review procedure for handling Blue Cross cases and give consideration to changes that will more directly involve the hospital utilization committees. (Under the present system, hospital utilization committees may be unaware of the action taken by the Second Councilor District Physicians' Advisory Committee).

On May 20, 1970, at a meeting of the Second Councilor District Review Committee chaired by Rudolph K. Glocker, M.D., all the above recommendations were approved.

THIRD DISTRICT *Ralph K. Shields, M.D.*

The thrust of the county medical societies throughout the Third Councilor District during 1969-70 has been greater involvement in the problems of the total community. This has been evident in the subject matter of the county medical society programs. There is an obvious concern about the many problems in the community with respect to health care delivery, the quality of medical care,

the cost of medical care, drug abuse and the manpower shortage in the health care field.

This concern is healthy, indeed it is essential. For only as we as physicians become involved in the shaping of health care delivery systems so can we determine the future of health care in the nation. Either we stand united in the

positive approach to provide what is best for our patients or by default we must accept what others dictate we must do.

The following are summaries of some of the more significant activities of the county medical societies in the Third Councilor District:

CARBON COUNTY

Stanley Cope, M.D., was chairman of the Benjamin Rush Award for 1969 which was presented to Mr. Winston Sherer of Palmerton.

The society again held its usual July outing with golf and dinner and was also entertained by the auxiliary at its annual Christmas party.

In 1969, Eugene E. Laigon, M.D., from Coaldale, was chairman of the mass rubella immunization program.

LACKAWANNA COUNTY

The past year has seen some change in the traditional schedule of one business and one scientific session each month. Strictly scientific topics have been alternated with socio-economic subjects. Among the several excellent speakers who have appeared before scientific gatherings were: Edward E. Wallach, M.D., assistant professor of the Department of Obstetrics and Gynecology of the Hospital of the University of Pennsylvania; Paul Numeroff, Sc.D., director of the Division of Nuclear Medicine of E.R. Squibb & Sons; Edward W. Gilmore, M.D., of Physician Service Associates of Binghamton, N.Y.; and Valentino D.B. Mazzia, professor and chairman of the Department of Anesthesiology at New York University Medical Center and professor of Anesthesiology in the Department of Oral Surgery at N.Y.U. School of Dentistry, who was featured speaker at a joint meeting of the medical society with the Scranton District Dental Society.

The nationwide problem of drug abuse and drug dependence prompted the society to sponsor a seminar for physicians to bring them the latest and most comprehensive information on this vital topic. A very successful conference was held for some 100 physicians and a representative group of area health and welfare agency executives, college and high school supervisory personnel, nurses, auxiliary members and medical assistants. The seminar was conducted in conjunction with the Commonwealth of Pennsylvania, Division of Drug Control and the Mental Health/Mental Retardation Program. Panelists included: Ellsworth R. Browneller, M.D., secretary of the Department of Health of the Commonwealth; Martin D. Kissen, M.D., director of the Institute for Alcoholism and Narcotic Addiction, Philadelphia; G. Victor Rossi, Ph.D., director of the Department of Pharmacology of the Philadelphia College of Pharmacy and Science; William F. Wieland, M.D., director of the Philadelphia Community Mental Health Consortium; Paul W. Wilcox, D.Sc., Division of Drug Control of the Pennsylvania Department of Health; and Paul R. Mazzoni, Esq., District Attorney of Lackawanna County. Louis J. Vitale, M.D., medical society director of communications and director of the Lackawanna County Child Guidance and Psychiatric Center, was seminar chairman and Mario N. Fabi, M.D., was moderator. The seminar

was conducted after a county-wide survey of area schools and physicians to determine the extent of the problem locally.

During the year the society cited worthy individuals for service to the medical profession and the community with special Benjamin Rush awards going to Leonard N. Wolf, Ph.D., vice-president for planning of the University of Scranton, and the women volunteers of the Scranton Chapter Red Cross Blood Program. Eugene A. Curtin, M.D., was in charge of arrangements for the presentations at a pleasant evening affair.

Currently a study is underway to determine means and methods of attracting a greater member participation in society meetings activities.

NORTHAMPTON COUNTY

During the PMS meeting in Philadelphia in October, Mr. Nicholas Dutko of Bethlehem received the State Society's Benjamin Rush Award for his work in helping to secure blood donors for patients who required open heart surgery. Mr. Dutko was interviewed on WFIL-TV at the time of the annual meeting and was the guest of the Northampton County Medical Society at the PMS meeting.

During this same period of time Secretary Joseph W. Fisher, M.D., was made a member of the governing body of the Greater Delaware Valley Regional Medical Program. This appointment along with others represents the first time that membership on this governing body has come from outside the immediate Philadelphia area. The local group involved in comprehensive health planning met with officials from the U.S. Public Health Service. This group was not approved as being eligible to receive funding because the local board of directors was not composed of 20 per cent disadvantaged citizens. On further questioning of the federal group, it was learned that there were no federal funds available whether approval was obtained or not. Further pursuit of the issue seemed superfluous.

Several organizations have come to the Northampton County Medical Society in the past year with requests for approval and endorsement of mass immunization programs against rubella. It has been consistently the stand of its board of directors that the society not participate as a unit in these programs, however, any member motivated to participate is quite free to do so.

During the year a new contract was negotiated with Blue Shield and Blue Cross for better coverage of society members. With some dissenting opinion of the membership, the new contract will include children of members who are full-time college students up to age twenty-four.

A request from the area vocational technical schools and the Northampton County Community College resulted in the appointment of Paul V. Kiehl, M.D., as the county society's adviser in the development of curricula for the training of paramedical personnel at these institutions.

The Citizen's Advisory Committee of the Northampton County Board of Assistance expressed a concern over the reasons for the lack of acceptance of people on public assistance in the offices of many physicians. Several members of the board of directors had a rather lengthy

meeting with the above committee wherein the case of the doctors was presented. The final outcome of this meeting remains to be seen as more activity is forecast for autumn.

The board of directors is presently in the midst of negotiations with the Northampton County Bar Association to formulate appropriate procedures for the evaluation of malpractice claims before litigation is filed.

In April a joint meeting with the Lehigh County Medical Society heard the subject of current medical legislation presented by Congressman Fred B. Rooney and Gordon Barrow, M.D., coordinator of the Georgia Regional Medical Program.

Again this year a Councilor District meeting was held May 9, 1970, at Pocono Manor Inn. A total of nineteen were in attendance including representatives from every county medical society in the Third District. In addition, the State Society was represented by President-Elect William A. Limberger, M.D. Members of the staff of the Pennsylvania Medical Society were present in the persons of

John Rineman, Larry Fosselman, Dane Wert, LeRoy Erickson and Robert Craig.

The program opened with a discussion by Dr. Limberger of the thrust of organized medicine today, its importance and the importance of participation. This was followed by comments from each county society representative regarding what can and should the membership be doing for the Pennsylvania Medical Society in organized medicine, and what can and should the Pennsylvania Medical Society and organized medicine be doing for the individual physician and county medical society. A general discussion followed staff presentations.

After the meeting a pleasant social hour was enjoyed by those in attendance who were joined by their wives who accompanied their husbands to Pocono Manor Inn. A fine dinner followed and the meeting adjourned.

It would appear that problems that beset county medical societies are similar in general throughout the Third Councilor District. These problems are attendance and participation on the part of the membership.

FOURTH DISTRICT *George A. Rowland, M.D.*

The four county societies of this district have had a functional and busy year. All have carried on regular scientific meetings and all have managed to discuss their own society business as well as social and scientific problems of the profession and the communities.

Northumberland and Schuylkill Counties continue to operate on the basis of six scientific meetings and one business and social meeting annually with interruptions in the winter and summer. This arrangement seems to work out very well since it avoids having meetings in the part of the year when travel is difficult as well as in summer, the usual vacation time. Columbia County is considering the possibility of switching to a similar program from its present monthly format.

Montour County does not have the attendance problem faced by its neighbors since most of its meetings are held in conjunction with Geisinger Hospital Staff functions. Even the society members who are not Geisinger men are located in the same community so that travel is rarely a problem. Schuylkill County did make one change in their meeting time from Tuesday evening to Thursday afternoon. This county has had an extremely successful series of scientific programs presented by the Jefferson-Penn State faculty. These have been well attended and the county medical society meetings are held immediately following these presentations.

In May, in what is becoming a regular event, Northumberland and Columbia Counties met jointly with a seminar-type presentation by a number of speakers on the subject of heart disease. Northumberland County has also scheduled a meeting for October to which members of adjacent county medical societies will be invited. Proposals to

increase the joint meetings in the district are under discussion in all societies.

Readjustments of minimum fee schedules are being considered in both Schuylkill and Columbia Counties. The pressures of inflation are felt by physicians throughout the area. All Fourth District counties have carried out rubella vaccination campaigns with most satisfactory results. It seems apparent that the pool of rubella susceptible children has been largely obliterated in the Fourth District. This should go a long way toward reducing the danger of birth defects in the crop of babies due in the next few years.

COUNTY SOCIETY AWARD

In this regard, it occurs to this councilor that the Pennsylvania Medical Society is missing an opportunity to cement relations with its component societies. In the past few years the physicians in most of the counties of Pennsylvania have carried out numerous public service projects of great benefit to the people. The most outstanding of these have been immunization projects against polio, measles, tetanus, and rubella.

I would like to propose to the House of Delegates that the Pennsylvania Medical Society set up a regular award for special activities carried out by county medical societies. This could be in the form of a simple plaque. When the award has been approved by the Board of Trustees a presentation could be made at a regular or special meeting by the councilor or other appropriate person and suitable notification could be made to the press. This spotlighting of worthwhile society activities would be another step to improving the image of organized medicine.

MULTI-COUNTY EXECUTIVE STAFF

Responding to a proposal of the Pennsylvania Medical Society Committee on Objectives, representatives of all four counties have been discussing the possibility of a joint effort in setting up an executive office.

Several meetings have been held. In December talks began in Elysburg, Northumberland County. Each society had at least three representatives who met with the Councilor and Messrs. Rineman and Small of the Pennsylvania Medical Society office. Enough interest was shown at that time that a committee was appointed to consider the matter further. In January the committee met at Lemoyne with executive secretaries from single and multi-county arrangements. They learned much about the advantages and problems associated with these plans.

Most of the original group met again in May at Pennsylvania Medical Society headquarters. A peculiar ambivalence seems to be developing among these men. Although they are disturbed about the increased costs and the possible loss of identity of county medical societies, they seem to recognize that there are desirable features about the proposal which should not be disregarded. They also feel that a trend is visible here. The gap between societies having executive staff services and those without them is getting larger all the time to the gross disadvantage of the voluntary organizations. Since that meeting more material is being collected and county society executive committees are being queried. The next meeting in the series will be held in the fall.

REORGANIZATION PROPOSAL

At the meeting in May, the proposal of the Committee on Objectives to reorganize the Pennsylvania Medical Society was presented to the representatives. Although they did not have an adequate opportunity to study the proposal, their reaction was largely negative. This was based on two points.

In the first place, physicians in the central part of the state are extremely unhappy about the Department of Health Human Service Regions which were instituted a few years ago and which this recommendation follows rather closely. This division of the state was apparently set up from Philadelphia or Harrisburg. It includes a very sensible first district including Philadelphia and the suburban area. The third district is identical with the present Fifth

Councilor District of the Pennsylvania Medical Society and is also compact and sensible.

The remainder of the state is chopped up in a confusing fashion. All of the other four districts are random and inconvenient but from the point of view of the representatives of the present Fourth Councilor District, a new super district that would include the widely dispersed cities of Johnstown, Altoona, and Williamsport, and combine counties that are closely related to Pittsburgh with those that relate much more sensibly to Wilkes-Barre, Harrisburg, and Philadelphia seems to be totally senseless. This arrangement not only combines unrelated market areas and areas of medical flow, but also disregards transportation so that there are neither interstate highways or good secondary road networks to bring this monstrosity together.

The second principal objection that the members of this group sensed about the model plan was more basic. It seemed to them that this would simply add a new complexity to the organization of the medical society. A new level of administration would be developed between the county societies and the Pennsylvania Medical Society, if county societies continue to exist. The difficulty of getting representatives of county societies together for regional meetings would be just as marked as getting them to the Pennsylvania Medical Society House of Delegates, especially in many cases where delegates would have to travel farther to regional meetings than they would to state meetings.

If the county societies were to die as a result of this new arrangement, many of the men felt that this would serve to cut many doctors off from organized medicine. With all the recognized drawbacks of county medical societies as they are now constituted, they do offer the average physician an easy method to meet with his colleagues and maintain at least a minimal appreciation of what is going on in organized medicine. Serious damage to this local organization could finally sever the last connection of many physicians with the American Medical Association.

The Fourth District is still largely disorganized. Doctors in general are not very interested in the American Medical Association and the Pennsylvania Medical Society. They are not especially happy about a raise in dues but the consideration of some of these new proposals has attracted attention and stimulated thought. Medical organizations are more alive in this district now than they have been for several years.

FIFTH DISTRICT *David S. Masland, M.D.*

On March 12, 1970, the Fifth District met at the Pennsylvania Medical Society headquarters for a preliminary discussion of the possibility of having some counties join together for the purpose of hiring an executive secretary. There was considerable interest expressed, at this first meeting, and a second meeting of representatives from

the district was held May 26. Several possible solutions were advanced at this time and the representatives were instructed to return to their counties to explore the possibilities further. It is hoped that at the annual meeting of the House of Delegates that this will be further explored.

ADAMS COUNTY

The Adams County Medical Society in the past year has had areas of purposeful activity. One has been a doctors' search committee, which in cooperation with the Hanover group, has raised funds from several clubs and interested individuals. These funds are being used to communicate their needs in attracting new medical people to the area. The Adams County Medical Society, also in cooperation with the Council on Education and Science of the Pennsylvania Medical Society, initiated a very successful eight-session continuing education program for physicians of the area. It is hoped that this program will stimulate more interest in the Adams County physicians in organized medicine.

CUMBERLAND COUNTY

Among the activities in which the Cumberland County Medical Society engaged was approval of a \$500 loan from the Medical Aid Fund for a Dental student from Boiling Springs to attend Temple University Dental School. On March 10, the Benjamin Rush Award was presented to "Meals on Wheels." Mrs. Van Orden accepted the award. The Rev. Francis Remlay received the individual award. On February 8, 1970, a sports injuries conference was held at Dickinson College. This was sponsored by the Cumberland County Medical Society and Dickinson College. There were eighty participants in attendance and the program was well received. On May 5, the annual dinner for pre-medical students was held at Dickinson College. Participants in the program included students from Dickinson, Shippensburg, Gettysburg and Messiah Colleges, Harrisburg Area Community College and Penn State Campus at Middletown. Hugh Bennett, M.D., associate dean at Hahnemann Medical College, was the speaker. The meeting was well received. In May the Cumberland County physicians cooperated with the Department of Health and administered over 12,000 rubella inoculations to the kindergarten through sixth grade children in all county schools.

DAUPHIN COUNTY

Since the last meeting of the House of Delegates, the Dauphin County Medical Society was instrumental in the formation of a Dauphin County Disaster Advisory Planning Council. Its purpose is to provide for the effective utilization of all available resources in the county in the event of a disaster which produces mass casualties. The society also continued its assistance to the Technical Committee which is active in the organizational efforts to develop a Hamilton Area Neighborhood Health Center for the City of Harrisburg. A study of the distribution of physicians in Dauphin County was completed by the society and a report made to the society's Planning Committee in September, 1969. As a result of this study and meeting, several projects were initiated, including assistance to the upper county residents in obtaining additional medical facilities for the area.

In cooperation with the Pennsylvania Department of Health and community organizations and schools, the society provided volunteer physicians for the rubella program which was conducted for kindergarten through fourth grade children of the Greater Harrisburg Area in December, 1969. Approximately 20,000 children received the vaccine. In addition, the society through its volunteer physicians provided free physical examinations for 150 or more children who attended the summer camp of the Police Athletic League (PAL) of Harrisburg in 1970. The society continued its financial support to the SAMA Chapter at the Milton S. Hershey Medical Center and renewed its sustaining membership with national SAMA. The society continued its emergency panel service for the public in cooperation with the Medical Bureau of Harrisburg.

FRANKLIN COUNTY

The Franklin County Medical Society draws attention to the need for increased numbers of physicians in this area, a need which your trustee believes is shared by almost all of the smaller counties in this district. Franklin County wishes to cite the work of Charles A. Bikle, M.D., who this year completed a five-year term on the Officers' Conference Committee. Dr. Bikle is also vice-president of our society and well deserves thanks for his work on the Officers' Conference Committee as well as his work in many other areas of this society. Franklin County is contemplating a rubella vaccine program, but has not initiated this at the time of this report. I was honored to speak to this society for the seventh consecutive year and have found them an active and interested county society.

LANCASTER COUNTY

Lancaster County reports that in an attempt to attract more members to their meetings they have changed the time from Wednesday at 9:00 p.m. to 4:30 on Tuesday, providing a snack for those going directly to the office. They report the results were not spectacular — the attendance is about the same — 25 per cent.

Increased awareness of need for involvement in community affairs was shown by (1) revamping the "on call for emergency" system, (2) greater activity in the Home Health Care Program, (3) aid in formation of a citizens group for working on the drug problem, (4) more efforts to coordinate comprehensive health planning throughout city and county through an advisory council and (5) by actions with the community council. In cooperation with other health care groups, a successful rubella vaccination program in Lancaster City School District and adjacent school districts was conducted.

For increasing the knowledge of their members, they held one meeting at the headquarters of the Pennsylvania Medical Society and had the appropriate staff men explain its working. They endorsed the preceptorship program of the Pennsylvania Association of General Practice with a \$600 contribution and helped welcome Lancaster's new Hilton Hotel with the annual dinner dance in May.

LEBANON COUNTY

The Lebanon County Medical Society enjoyed an active year with emphasis in the areas of medical education and preventive medicine. This society sponsored four one-day seminars in continuing education conducted by Jefferson Medical College and Pennsylvania State University. These sessions were well attended, not only by members of the Lebanon County Medical Society but also by the county osteopaths and Lebanon Veterans Administration Hospital staff. A similar series of programs is planned for the coming year. In March the society conducted a highly successful county-wide rubella immunization program; 7,720 children, comprising 83 per cent of susceptibles in kindergarten through fourth grade, were immunized. The success of this campaign was in large measure a result of excellent community cooperation. A seminar on sports medicine concentrating on football has been planned for August. This session will be designed for a lay audience of local coaches and others with an interest in student athletics.

PERRY COUNTY

The Perry County Medical Society reports that their county, which has a number of first or near first immuniza-

tion projects, has again carried on its tradition and given 1,800 school children rubella vaccination. This was done in cooperation with the Osteopathic Association in Perry County. The community health center project with OEO and local backing and SVRMP approval has made no material progress. A site has been donated for this center. The secretary of the society, William H. Magill, M.D., reports that a Planned Parenthood Clinic is functioning with Drs. Frank Belmont and Joseph Matunis in attendance.

YORK COUNTY

The York County Medical Society appears to be in a healthy condition for the year 1969-70. There were many meetings on drug abuse fostered mainly by auxiliary members in cooperation with the York County Medical Society for the benefit of the citizenry of York and York County. Sydney Cohen, M.D., director of drug research, Washington, D.C., spoke on his work with drugs, their use and abuse. York County Medical Society, in cooperation with the Pennsylvania Department of Health, conducted a rubella immunization program throughout York County with approximately 10,000 injections given. Closer liaison with the York County Bar Association and the York County Osteopathic Association has been achieved by President Robert L. Feldmann, M.D.

SIXTH DISTRICT *H. Thompson Dale, M.D.*

It was a rewarding pleasure to me to be reelected district councilor by the House of Delegates last fall, but through the year I have felt that I am not being called upon to help this Sixth Councilor District enough, nor do I feel well enough informed of the activities of the various societies.

Our fourth annual district councilor meeting for senior pre-medical students of Juniata College and Penn State University was held at the Nittany Lion Inn, State College, on Thursday, February 18, 1970. A snow storm decreased attendance, but William A. Barrett, M.D., the president of the Society, drove a rented car from New York City to State College to honor his speaking commitment because no planes were flying. We had seventy-five pre-medical students and forty physicians present to hear Dr. Barrett deliver an illustrated lecture on "Precision Modalities in Urological Diagnosis."

On May 24, 1970, we had a special district councilor meeting at the Spruce Creek Rod & Gun Club. Delegates to the State Society, secretaries, presidents and other interested physicians of the Sixth Councilor District were invited; and fifteen doctors came, including representatives from Huntington, Blair and Centre Counties. It was disappointing that no one was able to attend from Clearfield and Mifflin-Juniata County Societies. Mr. LeRoy Erickson of the PMS Council on Education and Science talked to us about the latest developments in the Society's continuing educational activities and reported on the Centre County Medical Society resolution dealing with

ambulance personnel training. Mr. Robert H. Craig, of the Council on Governmental Relations, spoke on legislative matters. Mr. David H. Small, Assistant to the Executive Director, discussed administrative services for a councilor district. Joseph M. Stowell, M.D., of Blair County, is chairman of a committee to study the possibility of an executive secretary for our Sixth Councilor District. A dinner followed the meeting.

BLAIR COUNTY

Mrs. Dale and I could not attend the annual dinner-dance and installation of officers meeting in January, because it conflicted with a previous commitment.

James A. Heimbach, M.D., president of the Blair County Medical Society, invited us to attend a meeting of this society on Tuesday, March 24, 1970. We were able to attend and enjoyed hearing PMS President William A. Barrett, M.D., speak on organized medicine.

Many members of this society are active in the Pennsylvania Medical Society—Drs. Heimbach, Hommer, Hoover, King, Magee, Pollock, Sheedy, Skinner, Stowell, and others.

CENTRE COUNTY

The Centre County Medical Society has nine meetings a year. They start with a business meeting, are followed by a

dinner and conclude with a scientific or socio-economic meeting.

On June 7, 1970, the annual Physicians, Druggists and Dentists Picnic was held at Mountain Acres Camp in the Seven Mountains. The usual excellent time was had by all.

The planned State College Mountain View Hospital, a branch of Centre County Hospital, is moving along and should be completed sometime in 1971.

CLEARFIELD COUNTY

This active society of twenty-two members has not been heard from this past year, but knowing the fine members as I do, I am sure they are doing an excellent job.

HUNTINGDON COUNTY

William B. West, M.D. has informed me that this society of twenty-five members has not had a meeting for over two years. This "frustrates" me, because these fine members of

SEVENTH DISTRICT *Robert S. Sanford, M.D.*

It has been a pleasure to serve the seven counties and the six county medical societies of the Seventh District. Cooperation from the counties has been most satisfactory. I continue to note the active part played by many of the members in activities sponsored by the Pennsylvania Medical Society. It is only through representation from county medical societies that organized medicine can achieve its goals.

During the past year I was able to visit five of the six county societies of the Seventh District. During these visits I was impressed by the sincere progressive attitudes of the members.

Clinton, Elk-Cameron, Tioga and Union Counties have held regular meetings concentrating principally on the use of scientific meetings and the presentation of programs up-dating medical knowledge.

Lycoming County continues to present outstanding scientific programs, the nature of which has always been sufficient to invite participation by members from other adjoining county societies as well as from the members of the Lycoming Society.

EIGHTH DISTRICT *David J. Keck, M.D.*

The following is a summary of the activities of some of the county medical societies comprising the Eighth Councilor District.

CRAWFORD COUNTY

Crawford County currently has forty-six active, one

our profession in this county are missing the opportunities afforded in an active society.

Only H. William Stewart, M.D., Dickinson Lipphard, M.D. and the ever-faithful Dr. West attended the district councilor meeting in February, 1970. Juniata College senior pre-medical students were well represented and their adviser from Huntingdon was also present.

MIFFLIN-JUNIATA COUNTY

On January 24, 1970, Mrs. Dale and I attended the annual dinner-dance and installation of officers of this active society which was held in the Green Gables Hotel in Lewistown. This was a fine social affair and was well attended.

We hope to have the senior pre-medical students from Juniata and Penn State entertained by the Council on Public Service in future years.

I am pleased to represent this group of some 300 physicians and always welcome calls from anyone about problems confronting component societies in this district.

Potter County has been occupied with reorganization of the hospital staff and there has been considerable successful care of the migrant workers mainly on an individual basis rather than by organization.

In recent months this councilor has spent time attending numerous organizational meetings which are endeavoring to unify efforts to establish eventual satisfactory comprehensive health planning for the central Pennsylvania areas. These meetings have been attended in an effort to safeguard the interests of the counties of this district. These planning operations are trying to prevent split group interferences which dilute the effectiveness of a united regional comprehensive planning organization.

In summary, this councilor is pleased to report the continued interest of the members of the component societies of the Seventh Councilor District. There is a definite "forward look" in the activities of the different societies which is so badly needed in the rapidly changing concepts of medical practice. With continued interest, I am sure that the year to come will be successfully met.

affiliate and three associate members. These members have had various activities including monthly dinner meetings, generally with a scientific speaker or a topic of interest to the medical community.

They have also revised the by-laws of the county society so this membership has been opened up to all physicians

holding an unrestricted license to practice in the Commonwealth of Pennsylvania, thus opening the door of membership to osteopaths.

Crawford County is part of the Western Pennsylvania Regional Medical Program. David Kirkpatrick, M.D., was elected to chair the committee on heart disease. It is hoped that many benefits will come from this union.

The auxiliary has been very active and has undertaken the project of furnishing a room in the Baldwin-Reynolds Home Historical Museum with medical artifacts.

The county society has been saddened by the death of two members, H.H. Walker, M.D., a former District Councilor for the Eighth Councilor District and C.E. Mullin, M.D.

ERIE COUNTY

Again the Erie County Medical Society had an active and interesting year. The following are a summary of the highlights of the past year:

(1) Sabin Scholarship Fund awarded \$3,000 to thirteen students and one group.

(2) Presented a resolution to the Pennsylvania Medical Society annual business meeting asking Blue Shield to review its consultation program, hoping for the development of a comprehensive coverage for consultation.

(3) Disaster drills were held in local hospitals in connection with local Civil Defense. John S. Chaffee, M.D., served as chairman of the medical team.

(4) Participated in the 1969 Occupational Health Award Program. Lord Manufacturing Co., Erie, Pennsylvania, was chosen to receive the county award.

(5) Revised and modified the by-laws under the direction of Hugh L. Allen, M.D., so as to conform with the State Society recommendations.

(6) Carl B. Lechner, M.D., who resigned as president-elect of the Pennsylvania Medical Society, was unanimously voted to the position of honorary past president and received the past president's medallion and all honors accorded with this honor.

(7) Endorsed the formation of a Comprehensive Health Planning Council to serve the Erie area.

(8) David J. Keck, M.D., was elected councilor of the Eight District.

(9) Participated in the heart, cancer, stroke programs of the regional headquarters, Buffalo, New York. George D'Angelo, M.D., participated in one of the telephone lectures at Hamot Hospital.

(10) Four membership meetings and dinners were held and monthly Executive Committee meetings with the exception of July and August.

(11) The bowling league was active and participated in out-of-state matches.

(12) Four successful golf tournaments were held, including a doctor-dentist match.

The membership of the society is as follows:

ACTIVE MEMBERS:

Regular	198
Temporary	4
Senior Active	9
Resident	1

Military 1

Total Active Members 213

AFFILIATE MEMBERS: 2

ASSOCIATE MEMBERS:
Regular 23

Total membership 238

NEW MEMBERS: (M.D. Physicians)

Charles Ferris	Chul Nam Lee	Samuel R. Lowery
Francis O. Lamb	Walter S. Finken	Joseph C. Ley
Paul Sandstrom	John A. Lange	Frank J. Theuerkauf, Jr.
		John H. Kuitert

DIED:

Boyd Ghering, M.D.

TRANSFERRED:

John R. Conover, M.D.
Juan Delgado, M.D.

MILITARY SERVICE:

Douglas C. Rist, M.D.

McKEAN COUNTY

The membership of this county has remained constant at twenty-nine, having lost one by death and a new member was added. In this respect, they have been more fortunate than most county societies but even so the members continue to be greatly overworked.

McKean County holds its meetings on alternate months at Kane and Bradford, with excellent speakers. They have also participated in the continuing medical education plan of the Pennsylvania Medical Society.

The society is planning to give several rubella clinics throughout the county this fall and is planning to continue with the second series of the continuing medical education program.

MERCER COUNTY

Mercer County held its usual dinner meeting at the Shenango Valley Inn with appropriate subjects discussed by the membership.

In March it was decided to inform the Northwestern Comprehensive Health Planning Council that Mercer County was dissatisfied with the medical doctor composition of the council, i.e. alternating one member with the osteopaths. After some correspondence with Mr. Gerald Farmer, he suggested that one permanent M.D. member and one permanent D.O. member be appointed. This was discussed at the following meeting and was voted as acceptable to the Mercer County Medical Society.

It was also decided to investigate the possibility of retaining a public relations professional to report on the county meeting with the purpose of analyzing and improving the M.D. image and negating information circulated after the Senate Finance Committee report. This is still under consideration and nothing has been finalized as yet.

Mercer County held its rubella vaccine program in April, 1970 and even though it was widely publicized, the attendance to this clinic was reported as being considerably lower than anticipated.

At the April Executive Committee meeting it was decided to send reprints dealing with M.D. memberships on the hospital board of directors to all members of the Mercer County society. As yet there have been no replies to the

inquiry but it is expected this will come up for later discussion.

Drs. Ricciutti, Rayboro, Woodings and Kline attended the PMS Officer's Conference in April at Harrisburg and felt it was worthwhile and constructive.

The Mercer County society in April endorsed Health-O-Rama which was conducted at the Shenango Valley Inn from June 3 through June 6, 1970. This was sponsored by the United Fund of Mercer County and conducted by the Health Research Service Foundation of Pittsburgh. The society was not required to participate in this program other than in an advisory capacity.

The Benjamin Rush awards were given on May 20, 1970; the individual award to Mrs. Lillian Rosenblum and the group award to Greenville Lions Club.

NINTH DISTRICT *Cyrus B. Slease, M.D.*

The District Review Committee has not been called upon during the past year.

A district meeting of officers and delegates of the component societies is planned for September 10, 1970.

The woman's auxiliary continues to be active throughout the district.

I wish to thank the component societies and individual physicians for their continuing cooperation and interest.

The component societies of the Ninth District are all active and have had regular meetings during the year.

Participation in State Society affairs has increased but still can be improved.

Activity in regional medical program and comprehensive

health planning is evident and involves several members of this district. More information on these programs will be found in the report of the Council on Medical Service.

Four of the six counties have been visited so far and the problems of shortage of general practitioners and excessive paper work continue. Considerable dissatisfaction with Blue Shield programs exists. This may in part be due to lack of understanding of the various programs.

On May 20, 1970 William A. Limberger, M.D., president-elect of the State Society and John Rineman, executive director, spoke to a combined meeting of the Indiana and Armstrong County Medical Societies at Indiana. This was an interesting and informative meeting.

TENTH DISTRICT *William J. Kelly, M.D.*

BEAVER COUNTY

The district censor of the Beaver County Medical Society reports a total membership of 155, of which number 148 are active with seven associate members. Their physicians are still kept busy speaking to different organizations and clubs on various aspects of medicine. Twenty-one Beaver County doctors spoke at thirty-five cancer programs and had audiences totaling 7,000 adults and children. The scientific meeting for September, 1969 was a combined one with the woman's auxiliary. At that meeting two of their veteran members were honored and presented with Fifty-Year Award plaques: Norman R. Crumrine, M.D., of Beaver and Mashel F. Pettler, M.D., of Beaver Falls. As is customary, the annual dinner dance was held on November 15, 1969 at the Beaver Valley Country Club. It was a gala occasion attended by the physicians and dentists of Beaver County. My wife and I were privileged to be guests at this

affair. This society again held a dinner for the medical students of Beaver County on December 26, 1969 at the country club. Twenty students with an equal number of doctors were present as well as the administrators of the hospitals.

In January of this year Robert I. Levy, M.D., head of the section on lipoproteins at the National Heart Institute spoke at a meeting. The coronary care unit nurses of each of the hospitals were guests for this meeting. The Program Committee of 1969 did an excellent job in obtaining speakers for scientific meetings. Their attendance has improved considerably and, I am sure, much of the credit is due this committee. A bus trip was arranged to the Cleveland Clinic for May 14, 1970. A varied program was presented by the Clinic Educational Foundation. This event

is held every two years and is always looked forward to by the members.

Beaver County conducted its first rubella immunization program on May 6 and 7. Thousands of children from kindergarten through fourth grade were immunized against rubella. The vaccine administration was conducted by school nurses and doctors within school buildings. They were assisted by other registered nurses and medical doctors. This program took the place of the Health-O-Rama that has been held in recent years.

In May of 1969, E. Wayne Martz, M.D., then associate director of the Western Pennsylvania Regional Medical Program (WPRMP), attended the board meeting to explain the work of the regional medical program. Drs. Herman Bush and John W. Lehman were appointed to represent the medical society. During June of 1969 a survey was conducted to determine the case load of rehabilitation patients in their county and the facilities available for these patients. The survey was done with the help of medical students from the University of Pittsburgh School of Medicine. Nicholas H. Krayner, M.D., of Beaver was appointed to head the subcommittee on heart disease and David Chamovitz, M.D., Aliquippa, headed the subcommittee on continuing education of the Beaver-Butler Area Advisory Group of the WPRMP.

LAWRENCE COUNTY

Regular monthly meetings of the Lawrence County Medical Society have been held. Routine business was transacted with the topic of executive secretarial help being on the agenda frequently. The secretary of this society is aware of the need for this help and continues to pursue this matter. There were two social functions this past year for members and their wives. In addition, the annual summer outing was held in June and was very well attended. My wife and I attended this function and had the opportunity to discuss the problems and activities of this society with the president and secretary during this enjoyable visit. I was impressed with the increased interest in the present officers in the activities of organized medicine, particularly with respect to the redistricting of the county societies and the rewriting of the Medical Practice Act.

April 4-8, 1970, there was a county-wide rubella clinic for children age one through the sixth grade. The clinic was sponsored by this society. Sixty-three percent of all eligible children received the rubella vaccine at this clinic.

Concerning this society's participation in the regional medical programs, it is my understanding that although this society does not participate directly, the three local hospitals in Lawrence County are involved in the program and their respective staffs are consulted and give advice. The extent of participation seems to be on an individual basis rather than a group basis.

This society is still making a very active effort to procure more physicians to practice in this area and has been successful in a few instances.

WESTMORELAND COUNTY

The society's membership as of December 31, 1969 totaled 239-218 active, nineteen permanent associate and two temporary associate members. Ten members died during 1969.

Ten excellent meetings were held throughout the year climaxed by the annual May Clinic held at the Pleasant Valley Country Club and a combined meeting with the Indiana County Medical Society, its auxiliary and the Westmoreland County Auxiliary at Torrance State Hospital. The members had dinner with the auxiliary on two occasions with interesting after-dinner speakers. The auxiliary entertained the society with a dinner-dance at the Greensburg Country Club and also dinner at the Latrobe Country Club honoring Dr. Day. The Westmoreland County Medical Society Scholarship fund renewed four scholarships and awarded one new one for 1970-71.

The very informative and concise bulletin of this county medical society continues to keep the communications between the society and its membership alive and functioning.

This society's continued interest in, and its hand on, the mental health pulse of this community is an on-going project and very beneficial to the community. The members are to be congratulated on their progress in this aspect of community health programming.

ALLEGHENY COUNTY

In 1970 the activity and interest in organized medicine on behalf of this society speaks for itself:

New Headquarters Building

The new headquarters building of the Allegheny County Medical Society at last became a reality and the society is now located at 713 Ridge Avenue in the northside of Pittsburgh. In addition to hosting society activities, the facilities are utilized by specialty societies and various community groups interested in health affairs. These organizations include the regional medical program, Hospital Planning Association, Blue Shield, the medical assistants, medical society auxiliary and surrounding county medical societies.

Branch societies of the Allegheny County Medical Society have been reorganized and stimulated to increase their impact in medical service planning.

The society continues to relate more significantly with various medical staffs of hospitals in the county, among many specialty societies and the community.

Poverty Committee

The society continues to be interested in improving health care delivery in all areas of the county, particularly where the need is most urgent. Discussions are continuing with the society's foundation, the regional medical program and the Pennsylvania Department of Welfare regarding the prospect of establishing a medical office building in the Hill District to serve people of low income groups.

Western Pennsylvania Regional Medical Program

Cooperation with the WPRMP was continued and various physicians served on committees. The society's president and executive secretary are active on the planning committee which is arranging the second annual RMP Conference in October. The conference will include progress reports presented by seven directors of projects which have been funded.

Allegheny County Council on Emergency Medical and Health Services

An operating grant of \$243,000 from the U.S. Department of Transportation to the Allegheny County Council on Emergency Medical and Health Services to improve emergency medical care in Allegheny County is pending. Medical society representatives have been instrumental in the council and serve actively on the executive committee and board of directors.

Comprehensive Health Planning

A CHP operational grant has been received and plans are under way to implement the program. A search for a full-time director has been in progress for several months without success. The medical society is represented on the board of directors and although appointments to the Medical Advisory Committee are not complete, a physician has been designated as chairman.

Rubella Immunization Program

In participation with the Allegheny County Health

Department, the society and foundation sponsored the *Stop Rubella Immunization Program* held on May 17. Approximately 200,000 children between the ages of twelve months to twelve years received the vaccine.

Physicians in the Tenth Councilor District, representatives of Pennsylvania Blue Shield, the United Steelworkers and the steel industry held a highly successful meeting in the society's headquarters. Approximately sixty persons attended the meeting which was arranged jointly with representatives of the county and state societies. This Councilor had the honor of moderating this meeting.

Concluding Remarks

In summary may I say that each of the counties in the Tenth Councilor District has continued to do its job and improve its stature. May I again report to this House that I have continued to supply each county society in this district with a condensed report after each meeting of the Pennsylvania Medical Society Board of Trustees. Each county is making progress relative to its own needs and responsibilities. In this changing world this is an accomplishment. I am honored to have been a very small part of it and wish to thank the members of these societies for affording me this privilege.

I would like to add that we were all very proud and happy to work with President William A. Barrett, M.D. We wish to congratulate him on his true and gentlemanly representation of the physicians of this great state this past year.

ELEVENTH DISTRICT *D. George Bloom, M.D.*

The first of two Councilor District meetings was held at the Marriott Motor Hotel, Philadelphia, October 9, 1969, before the annual House of Delegates meeting. Interest was high with only Bedford and Greene Counties not represented. Subjects discussed included:

A meeting of nurses and physicians scheduled at PMS headquarters on November 19, 1969 to which the chairman of each county society nursing committee was invited.

Provision of executive secretary services for county societies either individually or through cooperative arrangements.

Realignment of Councilor Districts.

Legislator contacts.

Problems associated with malpractice insurance.

The need for physicians to maintain contact with their legislators.

The Eleventh Councilor District met for the second time on June 3, 1970 at the Holiday Inn, New Stanton. All component societies with the exception of Bedford County were represented. The subjects discussed were:

Malpractice.

Political candidates.

Medicare and Medicaid fees.

Blue Cross-Blue Shield coverage by State Society.

Executive secretary for the District Councilor.

Participation in state councils and committees.

Councilor for the Eleventh Councilor District.

William C. Ryan, M.D., of Somerset, was appointed chairman of a committee to investigate the problems associated with hiring an executive secretary for one or more of the component counties on either a part-time or full-time basis. He will report back to the councilor.

Due to my physical disability in speaking and locomotion, I offered to resign providing the members felt I was not adequately performing the duties of the councilor in the district. There was unanimous approval that the duties were carried out satisfactorily under present conditions and a request that I continue as long as possible or until the expiration of my term was made.

In review of the Eleventh District's activities, it is the feeling of the councilor that there has been more activity than in previous years and with effective leadership the district can and will contribute to the well-being of the Pennsylvania Medical Society.

The only recommendation I make is that the councilor should have either an executive secretary or some secretarial help provided by the State Society.

Below follows a summary of the activities reported by several of the component county societies.

CAMBRIA COUNTY

In addition to the routine business of the society, a number of worthwhile scientific programs were conducted. In May, the society recognized the industrial health program carried on by the Glidden-Durkee Division, SCM Corporation.

Of long-term significance, the secretary noted in his annual report that there are twenty-five fewer active members practicing medicine in Cambria County since 1959.

Both the areawide Comprehensive Health Planning Agency and the Regional Medical Program have been in official contact with the Cambria County Society. Four members of the society serve on the board of directors of the Comprehensive Health Planning Agency. Approximately fifteen members of the society serve on Regional Medical Program committees. There is a need in Cambria County for greater involvement in and information about these programs.

While comprehensive health planning is just getting under way there, with a search being made for an executive director, three RMP grants are operative in the Cambria County area. They are: (1) The Regional Postgraduate Medical Faculty, (2) The Hypertension Management Program, and (3) The Regional Library System.

FAYETTE COUNTY

The following were some of the more important activities of the Fayette County Medical Society during the 1969-70 year:

Publication of a book on Fayette County members "Physicians in the Transition," by Ralph P. Beatty, M.D., covering 1922 to present.

Sponsorship of a continuing medical education program of ten programs in conjunction with State Society.

A joint meeting with the Fayette County Bar Association.

A joint meeting with pharmacists.

Several members are participating in Comprehensive Health Planning and Regional Medical Programs. They include Robert Peters, M.D., Ernest Somers, M.D., and Walter A. Lion, Jr.

GREENE COUNTY

The following are highlights from the activities of the Greene County Medical Society during 1969-70:

Support of Head Start Programs.

Participation in the Regional Medical Planning Commission meetings.

Cooperation with the clergy in medicine and religion activities.

Participation in Western Pennsylvania Comprehensive Health Planning Agency meetings.

The year 1969-70 was an active one for the Somerset County Medical Society. Highlights include:

Participation in Western Pennsylvania Regional Medical Programs.

Participation in the Academy of General Practice Preceptorship Program.

Correspondence and in-person opposition to the "Chiropractic Bills".

Participation in the State Society's continuing education program held at the Somerset Community Hospital.

SOMERSET COUNTY

The following were some of the important activities of the Washington County Medical Society during the 1969-70 year:

Cooperation with the Washington County Blind Association in sponsoring glaucoma screenings.

Sponsored Washington County Health-O-Rama (free medical screenings), a Central Washington United Fund activity.

Cosponsorship of a county-wide diabetes detection program.

Cooperation with the Washington County Tuberculosis and Health Association and the Pennsylvania Department of Health.

Transmittal to the State Society Board of Trustees and Councilors of a resolution endorsing a state arbitration board on malpractice cases.

Sponsorship of the annual medical-legal banquet with Paul Dudley White, M.D., as the speaker.

Presentation of the book *At Your Own Risk - The Case Against Chiropractic* to high school libraries in Washington County.

WASHINGTON COUNTY

Award of cash prizes in drug poster contest sponsored by the Woman's Auxiliary in county high schools.

Establishment of liaison between the county society and the Vo-Tech schools.

Presentation of health education programs spearheaded by showing of the film "Parent to Child About Sex" and films on drug abuse.

Cooperation with Canonsburg Jaycees in collecting pharmaceuticals for "Operation Concern."

Participation in the Benjamin Rush Award Program.

The Washington County Medical Society gained five new members, lost two by death and two by transfer.

CONCLUDING REMARKS

Since my last report I have attended a number of county society meetings including the November 13, 1969 meeting of the Cambria County Society at which it was suggested that members of the Somerset and Bedford County Societies be invited to attend the Cambria County meetings. These invitations have been extended. On December 3, 1969 I attended a Bedford County Society meeting at which Robert Lynch, executive secretary of the Cambria

County Society, discussed "Prevailing and Reasonable Fees" and the problem of executive secretary services. Attendance at this meeting was poor. On May 19, 1970 I attended a Somerset County Society meeting at which Charles L. Winek, Ph.D., from the Allegheny County Coroner's Office in Pittsburgh, spoke on toxicology. Attendance was excellent.

In April I consulted with Mr. Harold J. DeRolph of Community Services of Pennsylvania, Harrisburg, regarding the poverty program in Greene and Fayette Counties. The subjects discussed included unemployed miners, vocational training for nurses aides, practical nurse programs, operating room technician programs, mobile health units and programs for ambulance drivers and attendants.

Nine review cases on fee disputes came to my attention including seven from Cambria County, one from Somerset and one from Washington. These cases have been satisfactorily adjudicated by the councilor and the special review committee of the State Society.

I have maintained my interest in the problems of the allied professions through attendance at several key meetings. These include a meeting at PMS headquarters on November 19, 1969 with representatives of the nursing associations, a program for operating room nurses, March 16-18, 1970, sponsored by the American College of

Surgeons, Washington, D.C.; and a State Society sponsored meeting on June 10, 1970 with representatives of the nursing organizations.

It is my feeling that the professional nurse must take a more active part in the supervision of the paramedical and health teams in the delivery of health services. As you all know, Pennsylvania is one of the leading states where the physicians and nurses are openly discussing mutual problems in the delivery of health services.

I was privileged to attend the Student American Medical Association Annual Convention in Philadelphia on May 6, 1970. I was impressed with the sincerity and spirit these embryo physicians are bringing to the many problems which face the profession. I believe they will be a force for good on all levels of organized medicine. During the meeting, SAMA went on record as recommending that professional concern for one's patients dictates that a good physician or medical student should not smoke in the presence of patients. On February 26, 1970 I also attended a seminar on malpractice insurance held at the Conemaugh Valley Memorial Hospital, Johnstown.

I wish to thank the officers and members of all the county medical societies in the district for their participation in the preparation of this report and for making this year a successful one for the Eleventh Councilor District.

TWELFTH DISTRICT *Park M. Horton, M.D.*

LUZERNE COUNTY

The Luzerne County Medical Society has a total of 270 active, four affiliate and thirty-six associate members comprising the parent society, with offices in the Luzerne County Medical Society Building in Wilkes-Barre, and the Hazleton Branch. Mrs. Oliver Franey is the executive secretary. The society publishes a monthly *Bulletin* of which Edward R. Janjigian, M.D., is editor. The Board of Directors meets on the first Wednesday of each month and the general membership meets the third Wednesday of the month. The Hazleton Branch meets monthly and sends a representative to the parent society. Currently John J. Coyle, M.D., is the Hazleton representative.

The annual meeting of the Luzerne County Medical Society was held at the Treadway Inn, Wilkes-Barre, on January 24, 1970. At this meeting approximately 140 couples witnessed the installation of William Pearlman, M.D., as president, succeeding W.R.A. Boben, M.D. The individual Benjamin Rush award was presented to Mrs. Alfred Danoff for her efforts at improving the health and welfare of the children of the community. The group Benjamin Rush award was presented to the American Chain and Cable Co. of Wilkes-Barre for its program of hiring and rehabilitating the physically handicapped. Also at this meeting Fifty-Year Awards were presented to E.C. Bahn-miller, M.D., Wilkes-Barre; Angelo Luchi, M.D., Wilkes-Barre; and A.H. Gabriel, M.D., of Plymouth.

The Luzerne County Medical Society has sponsored

several projects during the year, the most notable being a series of twenty-six medical reports from medical schools in New York, on Channel 44, WVIA, Monday mornings at 8:00 a.m. with re-broadcasts on Sunday at 3:00 p.m. The society concluded a successful rubella immunization program on June 4, 1970, co-sponsored with the Pennsylvania Department of Health, the March of Dimes Foundation and the school districts. Total enrollment of susceptibles in the seven districts is 27,576, and the number immunized was 21,860, or 79 per cent.

The society has a very active advisory committee to the Northeastern Health and Hospital Planning Council. D.W. Kistler, M.D.; G.B. Davis, M.D., and J.G. Hyman, M.D., are active in the Greater Delaware Valley Regional Medical Program. The society held an all-day program at Irem Temple Country Club on June 25, 1970 featuring inter-hospital activities and a scientific program.

The Auxiliary to the Luzerne County Medical Society, with Mrs. Stephen Wartella, Jr. as president, has been very active and a report of their work is published in each issue of the *Bulletin*. Again this year the auxiliary sponsored a Doctors' Day on March 30, 1970, featuring a dinner-dance to honor all the medical doctors of Luzerne County.

BRADFORD COUNTY

The Bradford County Medical Society has seventy active members and four associate members. Warren C. Nagle, M.D., president, with the aid of the Program Committee,

prepared an interesting and detailed monthly program guide which he mailed to each member at the beginning of the year with suggestions as to the format of meetings. Each meeting was well planned with speakers engaged far in advance. These efforts resulted in interesting programs and good attendance, and indicate that county medical society meetings can be beneficial and enjoyable. A joint meeting of the society with the Bradford County Bar Association was held last December.

Many members of this society are active in the Susquehanna Valley Regional Medical Program, with William Beck, M.D., serving on the Regional Advisory Group, Joseph B. Cady, M.D., on the Heart Council, and James B. McQuillen, M.D., as chairman of the Stroke Committee. J.W. Carpenter, M.D., is on the Cancer Council, Kenneth K. Meyer, M.D., is on the Cancer Council of the Northeastern Section, and George W. Corner, Jr., M.D., is chairman of the Northeast Section Cancer Council.

The Woman's Auxiliary of Bradford County is very active and usually holds monthly meetings concurrently with the county society.

SUSQUEHANNA COUNTY

The Susquehanna County Medical Society has thirteen active members. Meetings are held monthly, except July and August, with an average attendance of 70 per cent. During the past year the society has had no special projects, but several of the members have been active in regional medical programs and comprehensive health planning, both with the Northeastern Health and Hospital Planning Council and the New York Penn Health Planning Council.

WYOMING COUNTY

The Wyoming County Medical Society has thirteen active members. This society holds four meetings a year. Most of the activities of the physicians in this county center about the Tyler Memorial Hospital which is an outstanding health facility for this rural but rapidly growing area.

The Susquehanna and Wyoming County Societies have not organized Women's Auxiliaries.

Sullivan County has no society.

COUNCILOR DISTRICT MEETINGS

There were two Councilor District meetings held during the year; the first being at the Marriott Motor Hotel in Philadelphia on October 9, 1969. Each society in the district was represented and subjects of common interest were discussed, as well as matters coming before the House of Delegates. The other Twelfth Councilor District Meeting was held May 23, 1970 at the Treadway Inn, Wilkes-Barre, with all county societies represented except Bradford. The officers of Bradford County were unable to attend due to a schedule conflict. At this meeting the State Society was represented by William A. Limberger, M.D., president-elect and Mr. John Rineman, executive director.

Dr. Limberger spoke on the thrust of organized medicine, its importance today and in the future. Mr. Rineman outlined some of the activities of the State Society and the many services provided for county medical societies.

Each person attending the meeting was given an opportunity to present his thoughts on activities of organized medicine at the county, state, and national levels. Much interest was evidenced and the comments made to this councilor following the meeting indicated a most successful Councilor District meeting.

SUMMARY REPORTS OF STANDING COMMITTEES

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Many items of importance to the auxiliary and the State Society were taken under advisement by the Advisory Committee at its meeting and by mail.

The committee reviewed the program for the Annual Mid-Year Conference held April 15-16, 1970. For the first time in the history of the auxiliary, a session was open to the public. A drug abuse forum was presented to an audience of high school students, educators, and auxiliary members.

Inasmuch as health careers recruitment is an increasing concern of all who are interested in providing adequate

health care, the auxiliary and its Advisory Committee are considering the establishment of an Auxiliary Health Careers Financial Aid Program to provide financial assistance to students who wish to continue their education in the allied health professions.

A report from the Council on Public Service of the Pennsylvania Medical Society suggesting that county auxiliaries consider approaching county medical societies concerning health education campaigns and that the auxiliary actively participate in the expansion of its Health Careers

Program by aiding with the establishment and sponsorship of "Careers In Health Clubs" was approbated by the Advisory Committee.

Women are such an important part of every political action group that it is commonly acknowledged that to have a successful campaign, politically sophisticated women are needed to win. A report proposing a program designed to promote "PaPMAC Membership for Women" was endorsed by this committee.

AID TO EDUCATION

The Educational Fund has provided 859 students with loans and scholarships amounting to over \$1,210,130 in the past twenty years. The members of the Pennsylvania Medical Society, through an allocation from the annual membership assessment, contributed \$940,834 to aid seventy-five children of deceased or disabled members of the Society in completing their education in high school, college and graduate school, and to help 631 students to attend medical school.

Of the financial aid furnished to the medical students, \$138,144 was used to provide full-tuition scholarship grants to twenty-six students, all of whom have graduated from medical school, while \$84,573 provided partial scholarships

The following auxiliary priority projects for 1970-71 received the consideration and approval of this committee: American Medical Association Education and Research Foundation, community health, health careers, legislation, and membership.

Proposed amendments to the bylaws providing that the treasurer may be a corporation or an employee of the auxiliary were reviewed and approved by the Advisory Committee.

for ninety-eight additional medical students. Loans to medical students exceeded \$805,000 in the twenty-year period.

Due to the increased cost of tuition and the necessity of giving assistance to as many medical students as possible, all of the monies available in the Educational Fund for the 1970-71 school year will be used for loans. It is anticipated that there will be approximately \$150,000 available from the Educational Fund for loans to medical students this fall, with other funds of the Educational and Scientific Trust providing about \$15,000 in medical student assistance.

The Committee on Aid to Education recommends that the \$8.00 allotment from the annual assessment of active members for the Educational Fund be continued for 1971.

CONSTITUTION AND BYLAWS

The Committee met on May 14, 1970, to consider an agenda which included referrals from the Board and correspondence, as well as items generated within the committee. Suggested language for all constitution and bylaw amendments is found in the "Official Call."

Membership For Interns And Residents — The recommendation that "active membership or its equivalent" be made available to interns and residents came to us from the AMA by way of a January Board referral. We agree that interns and residents should be members of PMS and its component societies and we have prepared the necessary amendments which appear in the "Official Call."

In so doing, we note that residents, licensed to practice in the Commonwealth, can already be active members at a special rate (10 per cent). Less than 150 residents now do so. So that a new category of membership entitled "Interns and Residents" can be an effective recruiting tool for young doctors, we propose to give them the right to vote and hold office, but be dues exempt. The prohibition against medical defense or benevolence would be maintained.

Voting Rights For Associate Members — In March the Board called for a constitutional amendment which would give the right to vote and hold office to associate members. Purpose of this move would be to bolster the membership

list submitted to the AMA thus insuring Pennsylvania's twelfth delegate to the AMA. The executive director reported to the Board in March that unless something were done, the Society would lose its twelfth delegate in 1971. We agree that giving the right to vote and hold office to associate members would be an easy way to solve the problem of declining active membership. Such a change, however, sacrifices a principle to an immediate problem.

We prefer to see active membership given to interns and residents; such a move to be followed by a vigorous recruiting campaign. "Resident and Intern" members would count towards the AMA delegation and the enlistment of 150 would guarantee the twelfth delegate. When we consider the number of interns and residents in Philadelphia alone, we begin to speculate about a thirteenth delegate.

SAMA Participation — Having recommended last year representation for each SAMA chapter in Pennsylvania, the committee wishes to add a postscript. We believe it would be appropriate for the secretary, in his annual report, to include something about the participation of SAMA delegates, so that the House may review annually the effectiveness of this franchise.

Mandatory Retirement Age For Members of the AMA Delegation — The Committee is mindful of the perennial

discussion regarding the choice of Society delegates to the AMA. Because term limit has not been acceptable, the Committee recommends that the House of Delegates consider the idea of a mandatory retirement age. Forced retirement is a mechanism accepted in business, education and the professions. Although frequently inconvenient, it forces organizations to move new blood in — and hopefully young enough blood so that replacements may acquire great expertise and enjoy long tenure.

Sturgis Standard Code of Parliamentary Procedure — The speaker of the House of Delegates has requested the Society to follow the lead of the AMA and switch from “Roberts Rules of Order” to “Sturgis Standard Code of Parliamentary Procedure.” The committee concurs.

DISCIPLINE

The Committee on Discipline held a telephone conference to handle the one case which formally came to its attention during 1969-70. Although declining to take jurisdiction, the committee did offer the good offices of its then incoming chairman, David Katz, M.D., Pittsburgh, to informally assist the parties in reaching a settlement. At this writing, negotiations are still open.

On April 13, 1970, committee's chairman Katz died, following a coronary in early December and a stroke on March 31.

Liaison with the Pennsylvania State Board of Medical Education and Licensure was maintained through the appointment of the board chairman as an ex-officio member of the committee (Charles B. Hollis, M.D., Philadelphia).

The survey of component societies regarding grievances

Exception of Term Limit for Chairmen of Councils and Commissions — The Board, concerned about recent high turnover of council chairmen, proposed an amendment in May which would permit the president-elect to reappoint chairmen up to three extra one-year terms beyond the current six-year limit on councils and commissions. We agree that experience and continuity of chairmen are important to the effectiveness of councils and commissions, but disagree that a bylaws change is necessary. We believe that presidents-elect, by choosing men earlier in their tenure, can achieve stability for councils and commissions. The purpose of the current six year limitation is to force new blood into Society administrative machinery. The amendment would impede this.

and disciplinary activities proposed in last year's annual report was completed. Details of the survey will appear in the Official Reports Booklet. With fifty-seven of the sixty county societies reporting or 95 per cent, the survey showed a total of 349 grievances received in 1969. Of these, 325 required committee action resulting in 304 cases being closed in 1969 or 87 per cent of the case load. One week or less was the time cited most frequently as being required to close a case, with the longest estimate being three to six months. Most grievance committees meet upon the call of the chairman.

Ten disciplinary cases were reported consisting of one suspension, eight censures and one case which was resolved. One county also reported a case of hospital staff disciplinary action.

MEDICAL BENEVOLENCE

Twenty-five family units received assistance amounting to \$40,785 from the Medical Benevolence Fund during 1969 in monthly grants ranging from \$50 to \$300.

During the year two widows of physicians—one of whom has five children to support—and one physician were approved for assistance by the committee. A loan was granted to assist another family in which catastrophic illness had exhausted financial resources.

One recipient died; she received a total of \$3,480 from the fund in seven years.

The committee acknowledges the strong financial support of the Woman's Auxiliary and its members. Their contributions amounted to \$7,865.50 in 1969. Other memorials and contributions brought total gifts for 1969 to \$8,275.50.

The financial details of the Medical Benevolence Fund are given in the Accountant's Report for 1969. It is the opinion of the committee that an allocation of \$1.00 per active member from the 1971 annual assessment will be adequate to finance the Fund for the year.

OBJECTIVES

Dr. Farrar, in his speech to the House last year, again recommended that a limit of three two-year terms be imposed on delegates to the AMA with the option of being re-elected, after an interval of one year. This proposal was referred to the committee which ordered a staff study of

the tenure of delegates during the past twenty years. Dr. Farrar's proposal was thoroughly discussed at several meetings before the committee unanimously arrived at the following recommendation:

The Committee rejects the concept of term limit as

proposed by Dr. Farrar in his address to the House in 1969 and recommends instead that the Committee to Nominate Delegates and Alternates to the AMA be enlarged to include one representative from each councilor district and that the Committee be instructed to nominate more candidates than there are offices to be filled.

We have also endorsed the recommendations made by George A. Rowland, M.D., in his letter to Park M. Horton, M.D., dated October 20, 1969, calling for:

- I. The names of committee nominees to be printed on the ballots.
- II. The Nominating Committee to summarize each incumbent's activities, including age and length of service; such summaries also to be prepared for new candidates.
- III. The report of the Committee to be presented at the time of election.
- IV. If the election is contested, any and all candidates shall have the right to seconding speeches.

Last year Dr. Farrar also called for the popular election of the president-elect, the four vice-presidents and the secretary by secret mail ballot of the entire membership. The committee surveyed 46 state societies but could find none which do this. Consequently, the committee is recommending that: the suggestion made by Dr. Farrar on October 9, 1969, concerning the direct election of Society officers by secret mail ballot not be adopted.

The 1969 House mandated the committee to submit a model plan for Councilor District reorganization. The model plan follows:

Councilor District Model Plan

as proposed by
The Subcommittee on Society Organization
and adopted by the Committee on Objectives
on April 29, 1970

It is proposed that the Pennsylvania Medical Society establish six regions, each region to have a Regional Board of Counselors. The regions are as follows:

<u>Region I</u>	<u>Region II</u>	<u>Region III</u>
Bucks	Berks	Luzerne
Chester	Lehigh	Bradford
Delaware	Northampton	Sullivan
Montgomery	Schuylkill	Susquehanna
Philadelphia	Carbon	Tioga
	Monroe	Wayne-Pike
	Lackawanna	Wyoming
		Perry
<u>Region IV</u>		<u>Region V</u>
Columbia	Lycoming	Allegheny
Montour	Blair	Fayette
Northumberland	Cambria	Greene
Snyder	Huntingdon	Washington
Union	Mifflin-Juniata	Westmoreland
Centre	Bedford	Armstrong
Clinton	Fulton	Butler
	Somerset	Indiana
		Clarion
		Venango

Region VI

Cameron	Potter
Clearfield	Warren
Elk	Crawford
Forest	Erie
Jefferson	Beaver
McKean	Lawrence
	Mercer

*Note

Representation on the Regional Board of Counselors would be from the county societies in the proportion of one representative for every 500 members or fraction thereof. Term of office on the Regional Boards would be five years with a maximum of two consecutive terms. Regional Boards would meet at least quarterly and be on call.

The Board of Trustees of the State Society would continue to be composed of twelve members, two from each region, and the president, president-elect, and immediate past president. Trustees would be nominated by their Regional Board but elected by the House, with a provision included in the Constitution for nominations from the floor. Trustees would serve as ex-officio members of their respective Regional Boards. The term of office for Trustees would continue to be five years with a limit of two consecutive terms. It is also proposed that terms would be staggered for both Regional Counselors and Trustees, so that the Regional Boards and the Board of Trustees would have continuity.

**Note – If the plan is adopted, the structure of any given region may be altered if deemed prudent or necessary for efficient operation.*

Functions

The Board of Trustees: would continue to manage the budget of the Society. The Trustees would continue to determine statewide policy for the Society between meetings of the House. The Trustees would continue to approve or disapprove all programs not specifically mandated or prohibited by the House.

Regional Boards of Counselors: would propose annual programs and budgets for their region which would be approved by the Trustees. They would serve as information receivers and transmitters; Regional Boards would review programs, functions, financing and organization of component societies. Regional Boards would coordinate and facilitate physician needs regarding private and public health related programs operating in that region. They would recommend policies to the Trustees.

Financing

The expenses of the Regional Boards (mostly transportation and meals) would be borne by the State Society by an apportion of State Society dues. The State Society would also provide staff for the Boards and their programs. While initially, the cost of operating the regional boards would

appear as an item in the State Society's budget, it is envisaged that at some future date, component societies within the regions would not be barred from coordinating their finances in such a way as to provide funds to the Regional Board for additional programs and staff.

State Appointive Offices

Regional Boards of Counselors would be responsible for providing lists of nominees from which the president of the State Society would make his appointments. They would also have the right to introduce resolutions in the House.

A major project of the Committee for 1969-70 was the drafting of long term objectives for the Society. Such long-term objectives could set the Society's course beyond the annual framework to which it has become accustomed. The Board of Trustees approved the objectives at its May meeting and forwarded them to the House. We earnestly seek your reactions to them and hope that they will receive wide distribution, not as dogma, but as a basis of discussion and further recommendation. We would be pleased to see them adopted eventually by the House.

01 General

01.1 The Pennsylvania Medical Society is vitally concerned with the maintenance and improvement of all aspects of the health and welfare of the people. It will initiate and support worthy efforts, private and public, that may promote these aims and will provide leadership where appropriate.

02.1 The Pennsylvania Medical Society will promote a climate in which its members can provide their patients with the best possible medical care, regardless of their ability to pay. With regard to our concern for all aspects of the health of our citizens, the Pennsylvania Medical Society will, through appropriate channels, identify and relate to all members of the health team. It will establish and maintain meaningful relationships with allied professions and hospitals.

03 Ethics, Discipline, Licensure

03.1 The Pennsylvania Medical Society will exert leadership on behalf of the public to assure that all persons providing personal health care meet satisfactory standards of training, competence, and performance.

03.2 The Pennsylvania Medical Society, which is the custodian of the good name of medicine in Pennsylvania, willingly exercises this stewardship in the interests of physicians, patients, and the public.

03.3 As the steward of the physicians' rights and the arbiter of medical ethics, the Pennsylvania Medical Society will provide leadership in establishing guidelines for the unfolding relationships with hospitals and others concerned with the delivery of health services.

04 Delivery of Health Care

04.1 The search for new and better methods of delivering medical care more efficiently and a concern for the cost of such delivery is a continuing challenge we accept and we will attempt to provide leadership in its planning.

05 Manpower

05.1 The Pennsylvania Medical Society accepts responsibility to evaluate the health manpower needs of the Commonwealth, and to assist the people of the state in meeting these needs. To these ends, it will inform the public of these needs and press for the establishment and maintenance of the necessary facilities and faculties.

05.2 The Pennsylvania Medical Society will provide funds to assist needy Pennsylvania students who seek careers in medicine and allied health fields.

05.3 The Pennsylvania Medical Society will continue to encourage and recruit candidates for medical and allied careers.

06 Education

06.1 The Pennsylvania Medical Society will participate actively in medical education by offering constructive suggestions to improve the content and quality of medical education in the Commonwealth.

06.2 The Pennsylvania Medical Society will assume the task of assuring that practitioners maintain and increase their proficiency.

06.3 The Pennsylvania Medical Society through its publications and meetings will foster an exchange of information among all those appropriate groups, both public and private, whose goal is the improved health and welfare of all citizens.

06.4 The Pennsylvania Medical Society will meet its responsibility to advise the public concerning good health practices.

06.5 The Pennsylvania Medical Society will cooperate with health departments and other appropriate bodies in studying and assisting in solving environmental problems. These include atmospheric and water pollution, thermal pollution, disposal of solid waste, and control of ionizing radiation.

07 Legislation

07.1 The Pennsylvania Medical Society will initiate and support legislation expected to bring the greatest health benefits to the citizens of Pennsylvania and will cooperate with all government agencies to the end that health programs may operate effectively and economically.

STUDY RELATIONS BETWEEN MEDICINE AND OSTEOPATHY

The committee reports that it had one meeting during the year to take stock of activities at both the national and state levels. Its most interesting discussion concerned the change in the Pennsylvania Medical Society's Constitution and Bylaws permitting qualified osteopathic physicians to

join the Society as directed by the 1969 House of Delegates. The committee is asking in its report that all county delegations to the House of Delegates be prepared to report the number of county society bylaw changes and the number of osteopathic physicians accepted into membership.

SUMMARY REPORTS OF SPECIAL COMMITTEES

GENERAL PRACTICE

This committee endorses the preceptorship program of the Pennsylvania Academy of General Practice and urges its support by all county medical societies.

All specialty societies were surveyed to find out if time spent in general practice was acceptable as partial credit toward filling the requirements of the Boards. Almost without exception, we found it is not.

The Perry Health Center has not made significant progress. This is due in part to its nonprofit status and in part to bureaucratic inertia and red tape. As of this writing, the "seed money" with which to hire architects and to provide other planning aspects has not appeared. There is a real need for a program of low interest loans so that area health centers can get started while still retaining local community control.

The chairman attended the First International Congress on Group Medicine in Winnipeg, Canada.

Desirable Goals

1. Departments of family practice must be established and supported in the medical schools.
2. Residencies in family practice must have a functioning

model of practice at the hospitals where the training is offered.

3. To make the specialty of family practice competitive, the archaic fee structure with its distribution curve skewed to the surgical side will probably need revision.

To achieve these goals, hospital-based family practice groups should be established.

Recommendations

1. That Pennsylvania Medical Society support the Yarbrough and Rooney bills in Congress, which provide assistance to medical school family health departments and family health training programs.
2. That to abet family practice in Pennsylvania, this House of Delegates should request the state legislature to mandate and finance departments of family medicine in all state-supported medical schools.
3. We endorse group practice as a preferred method of delivering health care. From the evidence gathered, group practice seems to be a more efficient method of delivering health care.

MEDICINE AND RELIGION

The committee, during the past year, has continued to pursue the objective of Medicine and Religion, to promote dialogue between physicians and clergymen in an effort to improve patient care and explore the increasing number of medical-moral issues.

The chairman of the committee attended the regional medicine and religion workshop of the American Medical Association during March, 1970. This is an excellent forum

for the interchange of ideas, particularly regarding program planning, and we obtained several suggestions which may assist us in future planning. After discussion of the various ideas by the committee, they will be communicated to county committees via the newsletter, which continues to be published twice a year.

Continued county medical society programming was promoted among county committees in the eastern half of

the state by a medicine and religion workshop held in conjunction with the Scientific Assembly of the Pennsylvania Medical Society in the fall of 1969. Since there was a similar workshop held in 1968 for county committees in the western half of the state, no workshop is planned for the coming year.

As reported last year, the course in mental health entitled "Counseling the Troubled Person" was endorsed by Joseph Adlestein, M.D., deputy secretary of Mental Health and Mental Retardation, for use in the comprehensive mental health centers. As a result of that distribution, the committee has received several requests from individual comprehensive mental health centers for additional copies of the course. In addition, the course was also distributed to regional representatives of Pennsylvania Mental Health, Inc. for use in its county activities. All county medicine and religion committees have received the course for use in planning future programs.

RELATIONSHIPS WITH ALLIED PROFESSIONS

The Committee on Relationships with Allied Professions has had many meetings during the year, and has, since the last session of the House, conducted two state-wide Physician/Nurse Seminars. These seminars were held in the headquarters building of the Society among physicians and nurses from throughout the Commonwealth. In addition, the committee reports, pursuant to Resolution 69-29, that it has held a meeting with the Pennsylvania Podiatry Association and that future meetings with this group are planned. The purpose of meeting with Podiatry is to accumulate

As was the case in March, 1968, the Board of Trustees declared March, 1970, as Medicine and Religion Month in the State. With the cooperation of the Council on Public Service, this has been a successful project and will be repeated in the spring of 1972. Many requests have been received for the most unique item of this year's Medicine and Religion Month, a tear out sheet placed in PENNSYLVANIA MEDICINE, regarding the interrelationship of medicine and religion, suitable for framing in a physician's office.

Attention continues to be directed to the development of a method for county medical societies to approach contiguous seminaries and offer curriculum and faculty assistance in areas of mental health, home and hospital care of the sick patient, and problems of medical ethics. After further refinement of the program, the committee is preparing to approach county medical societies regarding their willingness to participate in several pilot programs.

information suitable for printing in PENNSYLVANIA MEDICINE.

The committee also reports that it has held meetings with the Pennsylvania Licensed Practical Nurses Association for a discussion of this group's problems. In the past the committee has met with the Pennsylvania Funeral Directors Association and the Pharmaceutical Manufacturers Association, and stands ready, when instructed by the House or the Board of Trustees, to carry on conversations with other professions.

SUMMARY REPORTS OF ADMINISTRATIVE COUNCILS

EDUCATION AND SCIENCE

The following is a summarization of council activities:

Fund Raising -- In an analysis of funding educational activities, it seems evident that (1) little or no support will be available from regional medical programs; (2) that limited support will be available from major pharmaceutical companies; (3) that federal funds can be solicited only at the discretion of the Board of Trustees who has chosen up to this time not to approve previously submitted requests. The only major source of funding left is registration fees received from participating physicians.

Pennsylvania Board on Improvement of Health Care in Nursing Homes and Related Facilities -- The chief concern of this board is the pending licensure of nursing home administrators and establishment of training courses. A task force of the board has been working on developing the content of educational programs for updating nursing home administrators.

Pennsylvania Cancer Coordinating Committee -- Concern was voiced by the committee in the reduction of federal funds for cancer control which will result in the elimination of the Bureau of Cancer Control of the Public Health Service. A recommendation made by the committee would require that for hospital accreditation by the Joint Commission on Accreditation of Hospitals, an institution have a cancer program which shall include a cancer committee charged with the duty of reviewing the records of all cancer patients upon discharge.

Pennsylvania Heart Coordinating Committee -- Recommended that the Pennsylvania Department of Health be authorized to refer for competent medical review all heart grants for inclusion in the budget.

Pennsylvania Psychiatric Society continues to receive staff service from the council. This shared staff assistance has fostered close cooperation between the specialty society

and the Pennsylvania Medical Society with both appearing to be satisfied.

EDUCATION

Production of Physicians- The Pennsylvania Department of Education has been revising the Master Plan for Higher Education in Pennsylvania and was seeking from the Society a recommendation regarding financial support by the Commonwealth for medical education. The council stated that funds provided through the state legislature should be on an equitable base to all schools. Funding of medical education must be a long-term commitment. Financial support of \$6,500 per student for each legal Pennsylvania resident, full-time student, on a grant basis to Pennsylvania medical schools was suggested. An additional recommendation stated that an \$8,500 incentive grant be provided per medical student per year for each student enrolled above an average number determined between 1962 and 1967. A flexible formula should also be devised whereby increasing costs are considered as a factor for financial aid.

Meeting with Deans of Medical Schools on Preceptorships — Representatives of the council and the Pennsylvania Academy of General Practice met with the Deans Committee of the Philadelphia County Medical Society to discuss the establishment of preceptorship programs to interest medical students in general practice.

AMA Survey, Periodic Relicensure, Physician Recognition Award, Standards for Continuing Education as a Requirement for Membership — Several steps have been taken to establish a more effective voluntary continuing education program. The community hospital continuing education programs have been expanded. The AMA Council on Medical Education conducted a survey of our continuing education programs. If we become an accredited institution, all scientific programs presented by the Council then would be approved for credit toward the AMA Physician Recognition Award. It was recommended that the Society should not entertain thoughts of periodic relicensure. It should, however, require all of its members to have achieved the requirements of the AMA Physician Recognition Award in order to retain membership in the Pennsylvania Medical Society and should urge each of the component county medical societies to do the same.

Audio Tape Cassette Scientific Program Service — A feasibility study was approved to investigate the educational value of providing on a subscription basis to physicians an audio tape cassette service of abstracted current medical literature. The subject matter would be of clinical value to the primary care physician presented in the scanning method approach.

Videotape Library — Through the State Department of Education, the Society has initiated a videotape library of medical subjects to be used by Pennsylvania medical schools, hospitals, and other educational institutions. Institutions utilizing the service will pay postage both ways and mail in a blank videotape compatible to their equipment to the department's office in Harrisburg, who in turn will dub on their tape the material requested. The advantage to the institution is that they can maintain their own tape library

or they can erase and reuse the tape at a later date for new program material at a very nominal cost.

PMS-POA Seminar — The first medical-osteopathic seminar held April 4 in Camp Hill was acclaimed a success, and preliminary plans have been made for a similar event in 1971, possibly at Scranton.

Scientific Assembly — Since there were so many enthusiastic compliments regarding the 1969 Scientific Assembly at Host Farm Resort Motel, Lancaster, the Advisory Committee on Continuing Medical Education recommended that several more programs of this type should be held at the same site in the hope that an attendance habit pattern can be established for the members of the Society. The schedule for the 1970 Scientific Session covers four days with general seminars for physicians each morning and specialty seminars each afternoon. Three Pennsylvania medical schools — Hahnemann, Jefferson and Pitt — have helped to organize the morning seminars for this assembly and the remaining Pennsylvania medical schools will be asked to help with the 1971 assembly. One of the four days will be devoted to workshops and seminars on the development of interesting programs for individual and group courses in continuing medical education. Simultaneously for two and one-half days, nurses and allied professionals will be invited to attend a program arranged specifically for them.

Community Hospital Courses — A summary of registrations, attendance, and financial data for the twelve 1969-1970 courses in continuing medical education indicates that the community hospital programs offered by the council were successful. The local directors of the twelve community hospital courses have been contacted regarding the past programs and their interest in programs for 1970-1971. In addition, inquiries were directed to several areas of the state where nominal interest had been expressed in 1968. The reputation of these programs is growing and more areas are now interested in council assistance.

Educational Institute — Many organizations and institutions are planning and conducting programs of continuing medical education in Pennsylvania. This has resulted in multiple programs in some areas, at times on similar subjects, and no programs in other areas. A second, and just as serious, waste is in resources — teaching and financial, and the burden accepted by some institutions while others contribute little. The council believes a statewide organization should be created that will permit various sponsors and purveyors of continuing medical education to pool their resources without losing their basic autonomy. The organizational structure for such an institute should be an independent and completely distinctive group organized as a subsidiary of the Pennsylvania Medical Society allowing for allied organizations to have a voice in regard to the direction of the continuing education process. Development of this approach is still being considered by the council.

Flexnerizing the Allied Professions — The council prepared a resolution to be submitted to the June AMA House of Delegates requesting the AMA to undertake a thorough investigation of methods to bring allied professions under the guidance of AMA for training, discipline, and ethics by

setting forth a certain class of membership.

Medical Corpsmen — Adequately trained ex-corpsmen should be able to become a part of the comprehensive civilian health care system. The council recommended the placing of medical corpsmen in selected hospitals in Pennsylvania to perform duties such as traction technicians, orthopedic, pediatric or laboratory assistants, utilizing their highly skilled qualifications earned in their military service. Another program entitled MEDEX, Medicine Extension, has been developed in which corpsmen are screened and selected as good candidates for physicians' assistants. The council asked the legal representative of the Society to determine if any changes must be made in the Medical Practice Act to allow the use of corpsmen as MEDEX in physicians' offices.

Continuing Education for Nurses — The council recommended developing a series of one-day seminars conducted monthly for general duty nurses intended to reinforce and expand the scope of current knowledge required for effective nursing action and provide practical approaches for the nurse's everyday problems and patient care.

Licensed Practical Nurse Act — The council recommended the Society initiate legislation to remove the requirement in the Licensed Practical Nurse Act that states a candidate must have completed, with diploma, a high school education for admission to the training program to allow training to begin in the vocational-technical high school. Also approved was a change in age from 18 to 17 for application for a license.

Revision of the Medical Practice Act — The problems which deter the use of ancillary personnel or the physician's assistant in Pennsylvania are created by the antiquated Medical Practice Act. The council recommended that this act immediately be brought up to modern day standards and that selected members of the Society meet with the State Board of Medical Education and Licensure to review the act and introduce appropriate legislation.

SCIENCE

"White Paper" — A "white paper" on Emergency Health Services in Pennsylvania, identifying areas that are weak and the kind of information needed in a statewide program in emergency medical and health services is being developed by the Commission.

Emergency Room Courses — A series of "Malpractice in the Emergency Room" seminars were presented at Bloomsburg, State College, Wilkes-Barre, Shamokin Dam, Meadville, Lock Haven, Gettysburg, DuBois, and Lewistown.

Emergency Medical Training for State Police Helicopter Pilots — Twelve State patrolmen who pilot Commonwealth helicopters were given at Polyclinic Hospital, Harrisburg, in cooperation with the State Department of Education, in-depth training in emergency medicine.

TB Patients and the General Hospital — Representatives of the commission discussed the treatment of tuberculosis patients in general hospitals. It was agreed that because of the use of drugs to control its infectiousness, tuberculosis is no longer a problem to treat in general hospitals.

Smoking Restrictions in Hospitals — The Board of Trustees adopted the commission's recommendation that the Society oppose smoking in hospitals, except in areas so designated by the hospital administrator.

Great Lakes Pollution — The Society was represented at a conference in Toronto, Canada, which discussed the pollution of the Great Lakes Waterway. Eight states (New York, Pennsylvania, Ohio, Illinois, Michigan, Minnesota, Wisconsin, and Indiana) and two provinces of Canada (Ontario and Quebec) border the Great Lakes. The meeting enabled the various associations to exchange information, compare the problems, and review any answers which had been evolved.

Information and Referral Service for the Aged — The commission requested the secretary of the Department of Public Welfare to review the Society's long pending recommendation for an informational and referral service for the aging in Pennsylvania.

Extended Care Facilities — Cosponsored with the Hospital Association was an invitational conference, which sought solutions to problems encountered by general hospitals in the provision of extended care services. Because of government inaction, nothing has been done regarding the proposals, that were approved by the 1969 House of Delegates, to improve the Title XVIII program. Since these improvements could benefit all of our aging citizens, we are asking the House to urge immediate implementation.

Pre-School Vision/Hearing Screening — In conjunction with a representative number of interested organizations, the Society has distributed to all county medical societies a kit outlining details for establishing pre-school screening for hearing and visual acuity.

Eugenic Sterilization — The commission will conduct a symposium on eugenic sterilization with prepared presentations representing all points of view with the thought of publishing the data. Hopefully the discussion will develop enough area of agreement so recommendations can be made on an authoritative basis to be sent to the legislature.

Commitment of Protesting Patients — Because of the restrictions placed on the use of Section 404 of the 1966 Mental Health/Mental Retardation Act, urgent treatment of many cases is unnecessarily delayed. A letter was sent by the Society to the attorney general requesting that the intent of Section 404 be literally interpreted to permit a protesting patient to be committed after examination by two physicians.

Sports Medicine — The Second Annual Conference on Practical Application of Physiology to Sports Medicine was held June 17, 1970 at the Pennsylvania State University. It was conducted by the Laboratory for Human Performance Research of the University.

Conceptual Guidelines for School Health Programs — Copies of a comprehensive health education curriculum guide, recently published by the Pennsylvania Department of Education, have been sent to county medical societies and some 1,200 school and team physicians throughout the State. The prime purpose of this guide is to assist schools,

public and private, in the development and implementation of health education programs.

Pennsylvania Committee on Smoking and the Health of Youth — The January 12, 1970 observance on smoking and health was declared a marked success. Three kickoff luncheons were held at Harrisburg, Pittsburgh, and Philadelphia. Seven college smoking conferences were held for future

teachers. The booklet, "Resource Unit on Smoking and Health for the Teacher," has been reprinted.

Council Priorities: 1970–1971 — To obtain the goals of the Long-Range Plan for the council and to maintain a high level of professional competence in the membership, priorities of programming activities have been determined by the council.

GOVERNMENTAL RELATIONS

The Council on Governmental Relations reports a continuation of the busy 1969–1970 legislative session with the Society's active interest in almost fifty measures. It reports the successful passage of The Uniform Anatomical Gifts Act, Effective Consent for Minors to Treatment Act, The Professional Corporations Act and The Renal Dialysis Act.

The council announces that a supplementary report will be filed on all measures at the time of the Annual Session of the House of Delegates.

The council reports on a series of House of Delegates'

referrals made to it, including the presentation made by Carl B. Lechner, M.D., in which he emphasizes need for increased political and legislative activity; as well as resolutions on air pollution control, therapeutic abortions, a separate Department of Mental Health, and other assignments.

The Commission on Forensic Medicine reports interesting developments concerning the medical examiner system and liaison with the Pennsylvania Bar Association concerning medical malpractice problems, etc.

MEDICAL SERVICE

The following report is a summary of the most significant activities and actions of the Council on Medical Service during the past year.

The council:

Continued to assist and advise Pennsylvania Blue Shield in the development and expansion of the Prevailing Fee Program by offering guidance in the development of new doctor profiles.

Provided continuing consultation to Pennsylvania Blue Shield with respect to their role as carrier for Medicare, Part B, CHAMPUS, and as fiscal administrator for Pennsycare by outlining several Medicare claim processing problem areas and recommending administrative changes for improvement.

Assisted in the functioning of Regional Blue Cross Physician Advisory Committees which are organized to evaluate hospital utilization problems presented by Blue Cross plans.

Continued to monitor and present testimony, where appropriate, at public hearings conducted by the Pennsylvania Department of Insurance relative to Blue Cross rate increase requests.

Continued the development of the Western Pennsylvania PMS — Blue Cross Regional Steering Committee which has the primary function of supervising utilization review activities, by requesting approval to have osteopathic physicians serve on the Regional Steering Committee.

With the cooperation of the specialty societies in Pennsylvania, completed the organization of nineteen Specialty Advisory Committees which are set up to evaluate disputed fee cases and utilization problems presented by third party carriers.

Continued to meet with representatives of various

governmental agencies and Medicare carriers in an effort to improve liaison and to develop a better understanding of the Society's review activities.

Continued to meet with representatives of the Department of Public Welfare in an effort to seek improvements in our Medicaid program. The council specifically urged the Welfare Department to develop hospital utilization review regulations which would be consistent with Medicare requirements and continued to urge the Welfare Department to contract with Blue Cross and Blue Shield to underwrite the Medicaid program.

Continued to study the complex problems confronting practicing physicians in the area of malpractice insurance and to assist individual members, upon request, in obtaining such coverage.

Continued to assist members and interested agencies throughout the state in the development of comprehensive health planning and provided liaison with the Pennsylvania Office for Comprehensive Health Planning.

Approved a survey of county medical societies to determine the extent of their activities in comprehensive health planning and regional medical programs.

Approved a survey of hospitals in Pennsylvania to evaluate the trend of hospitals employing physicians full time.

Maintained close surveillance over Society-endorsed insurance programs and approved the offering of a group life insurance plan.

Studied the feasibility of offering a statewide Blue Cross–Blue Shield program for members.

Sponsored a meeting with representatives of the steel industry and Blue Cross and Blue Shield to review the steel industry health care program.

PUBLIC SERVICE

The activities of the Council on Public Service have increased in the past year in all major areas of its many responsibilities. Measuring what has been done can be impressive until one considers all that should be done.

Considering human nature, the direction of today's social philosophy and the limited funds available, the Council on Public Service can do little more than fight a rear guard action that is designed to give medicine a voice in the third-party decisions affecting it.

It is increasingly apparent that a growing number of the members of the Pennsylvania Medical Society are not aware of the council's many public relations and public service activities and purposes.

It costs money to communicate with you, the members of the State Society, and the effectiveness of communications often depends on the amount of funds available. All too often we are not heard because of the intense competition for your attention and because the council has chosen to spend the dollars available to it for projects designed to influence the public rather than on membership communications. It has felt that it is more important in this era to communicate with non-members — the public at large. Now it fears that it is at a time when it must divert funds from projects designed to influence the public and use them for membership communications and a study of this is underway.

Those arrayed in opposition to the philosophy and goals of organized medicine are spending massive amounts of funds to achieve their ends. By comparison, the funds available to the Pennsylvania Medical Society are almost miniscule. Even so, the public relations and public service dollar is doing yeoman's duty, sometimes with the help of friends such as the members of the Pennsylvania Federation of Women's Clubs.

One of the most far-reaching activities of the council has been the drug abuse effort developed jointly with the federation which provided \$10,000 toward the production of filmed sound and color announcements distributed to all of the television stations in the state. These were followed with announcements to radio stations, speeches by Speakers' Bureau members, the distribution of thousands of drug abuse booklets, radio drug abuse documentaries and the distribution of films donated by the Woman's Auxiliary to the Pennsylvania Medical Society and by Pennsylvania Blue Shield.

In other areas, ninety radio stations across the state carry the Council's weekly health news program; health messages recorded by physicians are transmitted with a special telephone link to dozens of stations on a regular basis; docu-

mentary programs for radio on a variety of topics are distributed regularly to as many as 100 stations; and "spot" films on health subjects in addition to drug abuse have been distributed to TV stations.

For printed media, news releases, feature stories and a weekly health column are distributed on a regular basis to all or part of the more than 400 daily and weekly newspapers across the state. Leaflets and pamphlets on a great variety of health education and socio-economic topics are distributed by the thousands to requesting organizations and groups.

The council administers the Benjamin Rush Awards program, the Donaldson Awards for outstanding newspaper, radio and television reporting, the Centenarian Awards for those who achieve the age of 100 and the Fifty-Year Awards for physicians who have been in practice that many years.

The council administers the Speakers' Bureau which fills hundreds of requests and reaches thousands of persons annually. It conducts a health careers recruitment program and maintains Health Careers and Future Physicians Clubs. It has developed and presented trial courses on the socio-economic aspects of medicine for interns and residents and it meets regularly with medical students to seek mutual understanding. It assists the Pennsylvania Association of Medical Assistants and is repaid many times over by these stalwart friends of the physician. It maintains liaison with rural organizations, holds rural health conferences, and operates the Physician Placement Service with which it tries to meet medical coverage needs in rural areas. Health education exhibits are presented at major public gatherings.

It regularly produces and distributes to county medical society bulletin editors a compilation of news for and about physicians. It conducts day-long orientation visits at the state society headquarters for county medical society secretaries and other officers. It contacts, on a regular basis, physicians in the state who are not members of the county or state medical society and attempts to motivate them to apply for membership. The council produces annually the Service Manual which is distributed to key state and county society officers and which provides a ready reference to all the major activities of the State Society. The council assists county societies in public relations activities to the limit of its ability to do so, and maintains a solidly booked film library with presentations on health careers, drug abuse and medical public relations.

The council feels that these and the other activities not even mentioned here are all valuable and productive and thus it feels that it will be unfortunate if it must decrease these activities in order to improve communications with State Society members.

PENNSYLVANIA DELEGATION TO THE AMA

As mandated by the 1969 PMS House of Delegates, the Pennsylvania Delegation to the American Medical Association introduced two resolutions during the Clinical Convention of the AMA held in Denver, Colorado, November 30—

December 3, 1969, on medical staff rights and a national group "umbrella" insurance study.

The Annual AMA Convention was held late in June, 1970.



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SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

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WARNING: Do not give in advanced kidney or liver disease. **PRECAUTIONS:** Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

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NOTE: The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.



Ocular Complications of Cardiovascular Drugs

Benjamin F. Souders, M.D., chairman of the Section of Ophthalmology, Department of Surgery, Reading Hospital, West Reading, Pennsylvania, is questioned by William G. Leaman, Jr., M.D.

How often have ocular complications of drugs used in the treatment of C-V disease been reported?

Ocular complications are infrequently seen with the use of the approximately twenty-five therapeutic agents currently in vogue for the treatment of cardiovascular conditions. Considering the specificity of action and the awesome potency of many of these agents, it is surprising how seldom significant ocular signs and symptoms are manifested. A perusal of review articles dealing with pharmacology and toxicology in one of the leading ophthalmic journals revealed no mention of any such complications during the past three years. Occasionally, however, whether due to high inherent toxicity of the agent, a cumulative dosage effect, a synergistic effect of drug combinations, or even a peculiar patient susceptibility, ocular manifestations may be noted.

Have you seen ocular complications of digitalis or its derivatives?

The outstanding offending agent in considering this subject is digitalis or its glycosides. Ocular symptoms may occur with commonly employed doses, and include blurred vision, "snowy" vision, flickering dots and disturbances of color vision with chromatopsia. Signs of optic neuritis with scotomata have been reported as well as transient cortical blindness and extra-ocular muscle weaknesses. The phenomena are always reversible by decreasing or withdrawing digitalis. The rarity of the ocular signs of

digitalis toxicity today speaks well for proper regard given to use of this type of agent by clinicians.

What about quinidine?

Quinidine has the potential for causing retinal and optic nerve damage because of its cinchona derivation, but visual disturbances with this drug are rare.

Are any other anti-arrhythmic agents capable of causing a visual effect?

Propranolol hydrochloride (Inderal®) is a beta-adrenergic blocking agent used in arrhythmias, and it can occasionally cause visual disturbances. Procainamide hydrochloride (Pro-nestyl®) is related to procaine with cardiac actions similar to those of quinidine. It has anti-cholinergic properties and may potentiate the action of other anti-cholinergic drugs. It should, therefore, be used with caution where the possibility of glaucoma of the narrow-angle type exists. The same consideration must, of course, be made with the use of atropine. Diphenylhydantoin (Dilantin®) has recently been found to be useful in the control of certain arrhythmias. There is a profusion of ocular complications with the use of this agent noted mostly for its prolonged use in the treatment of convulsive disorders. These include nystagmus, diplopia, ptosis, mydriasis and transient blindness.

Do the nitrate compounds result in ocular complications?

The long-acting nitrate compounds exemplified by erythrityl tetranitrate (Cardilate®), isosorbide dinitrate (Isordil®) and pentaerythritol tetranitrate (Peritrate®) have been suspected of elevating intraocular pressure. A recent report considers this a mis-

conception based on an erroneous theory of glaucoma. It is felt that none of these drugs causes or significantly aggravates glaucoma.

Are there any ocular effects of the rauwolfia alkaloids?

The rauwolfia alkaloids have a considerable tolerance from the ocular standpoint, but overdoses have been reported to result in ptosis and miosis.

Do any other drugs have an ocular side effect?

The diuretics, furosemide (Lasix®) and ethacrynic acid (Edecrin®) are reported to cause blurred vision and altered color vision. Hexamethonium, a ganglion blocking agent, can result in mydriasis and cycloplegia with near vision blurring, in particular, and its use could be a precipitating cause of glaucoma in a susceptible eye. The drug has also been reported to result in loss of vision from its effects on the optic nerve or retina. Thiazide compounds may cause xanthopsia, myopia and retinal edema.

As an ophthalmologist, what general conclusions have you reached regarding the ocular effects of cardiovascular drugs?

This enumeration of the common cardiovascular drugs causing ocular complications is far from complete. However, such complications should be borne in mind when ocular signs or symptoms develop with the use of these preparations and should suggest a dose reduction or substitution of another agent.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

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symptoms
that bother him
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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X-Ray Diagnosis of Cancer

X-Ray and the Asymptomatic Patient

It is true that cancer of the lung, bowel, breasts and kidney lend themselves to radiodiagnosis while still early and limited in size. While radiologic surveys of large numbers of well people are not yet feasible, such surveys in high risk patients seem worthwhile. In this group would be chest x-rays in heavy smokers, mammography of the remaining breast after mastectomy for carcinoma, colon x-ray in patients with familial polyposis and stomach x-rays in patients with primary pernicious anemia.

The Patient with Symptoms

The refinement of technic, equipment and interpretative skill has given radiology its foremost place as an adjunct in the diagnosis of cancer. It must be emphasized that the radiology report is an interpretation dependent on the quality of the equipment and the skill of the radiologist. A report positive for cancer should always be confirmed by biopsy before definitive treatment is instituted.

Gastrointestinal Tract

In this area, radiology is the most important diagnostic method. The esophagus, stomach, small and large bowels lend themselves to early x-ray diagnosis. In the large bowel digital examination and proctoscopy should always be followed by barium enema study before a patient is assured he has no evidence of cancer. Where a colonic polyp has been found on proctoscopy, an x-ray examination should always be done to determine the presence or absence of additional polyps before treatment is instituted.

As we go cephalad in the gut, an unexplained anemia demands an x-ray of the colon as well as the small bowel and other studies.

The value of x-ray examination of

the stomach for cancer is well recognized. In addition the x-ray study in conjunction with the medical treatment of gastric ulcer will often be able to indicate need for histologic study regardless of subjective improvement.

The esophagus also lends itself to x-ray diagnosis and a complaint of dysphagia should never be dismissed without x-ray study.

Lung

Unfortunately by the time most lung cancers manifest themselves on the x-ray film they are usually too advanced for cure. The occasional exception to this is the peripheral nodule or coin lesion. Some investigators have reported a five year cure rate as high as 40 per cent in these lesions. All such lesions reported by the radiologist should be subjected to histologic study.

Breast

Mammography is steadily gaining

importance as a tool in cancer control. The value of mass screening surveys has yet to be established. It is extremely useful when clinical findings are not clear and can often localize a nodule the surgeon wishes to remove and, following surgery, can confirm its removal. In patients who have cancer in one breast, mammography should be done on the other breast to show, first of all, that the cancer is not bilateral and, in regular follow-up mammography, to detect the development of another neoplasm.

Urinary System

The abdominal scout film is one of the most useful tools in the detection of kidney tumors and is second only to the chest x-ray in survey studies. The pyelogram and other special procedures such as the arteriogram have made the diagnosis of urinary tract cancer increasingly precise.



CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

**I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.**



indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient, persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine,

mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand

and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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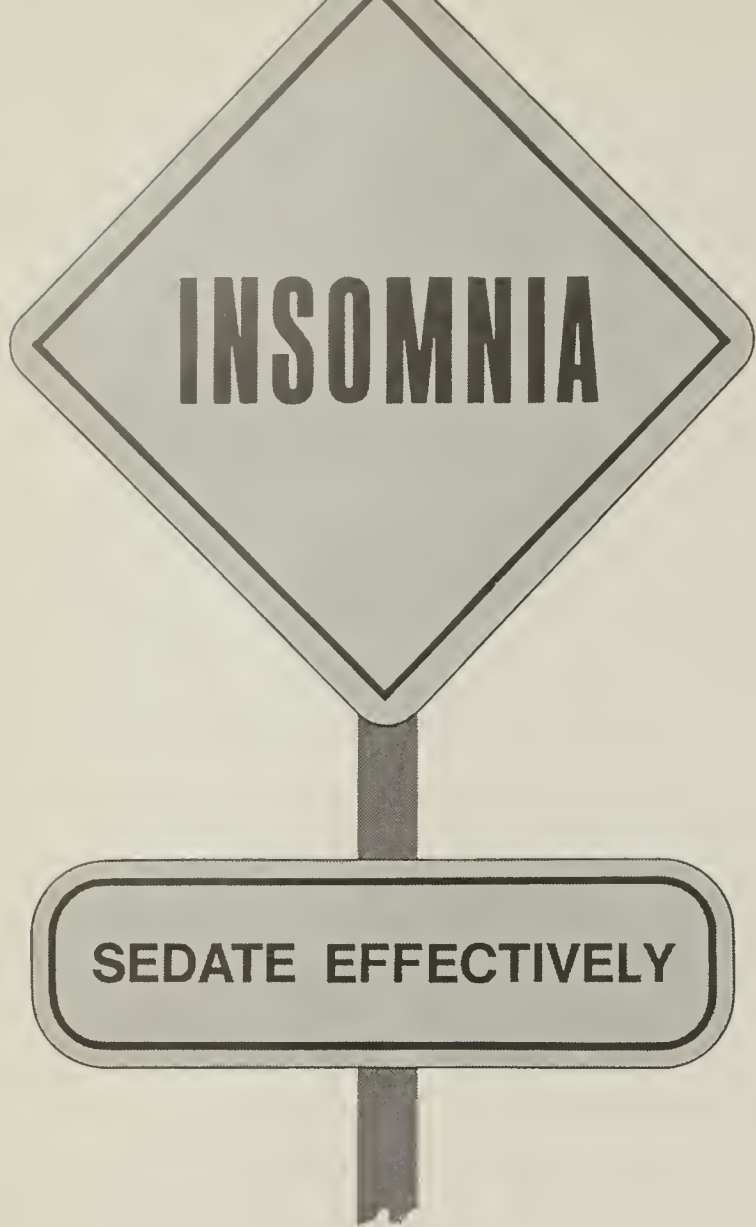
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SEPTEMBER, 1970



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PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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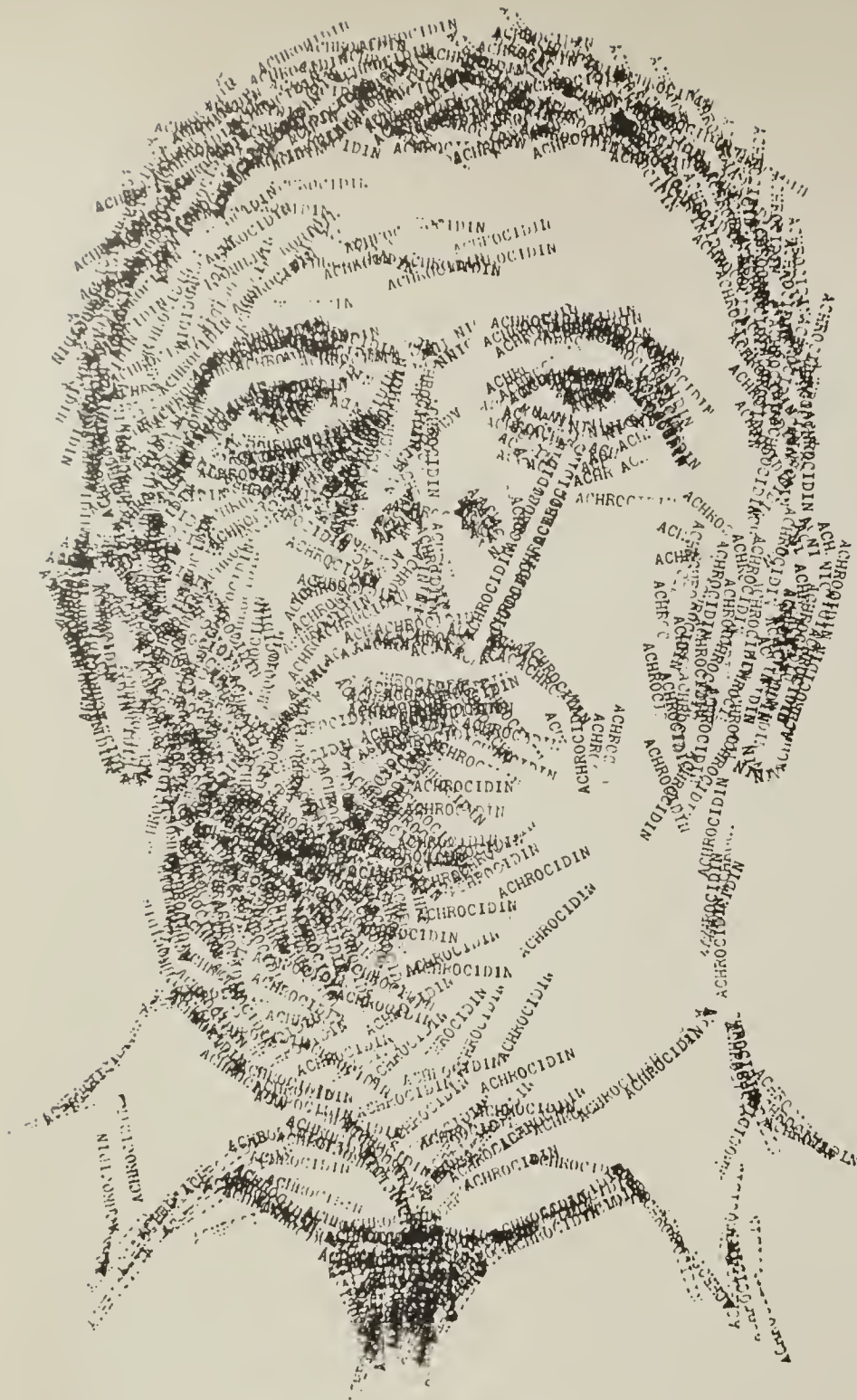
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebotic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic).

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and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10

mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, J. F.; Alman, R. W.; Tickin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: *Angiology* 15:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: *Curr. Ther. Res.* 4:124-128 (April) 1962. (5) Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964. © 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 75970

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ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

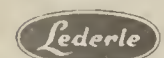
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons

on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculo-

popular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



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not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

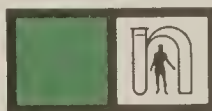
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

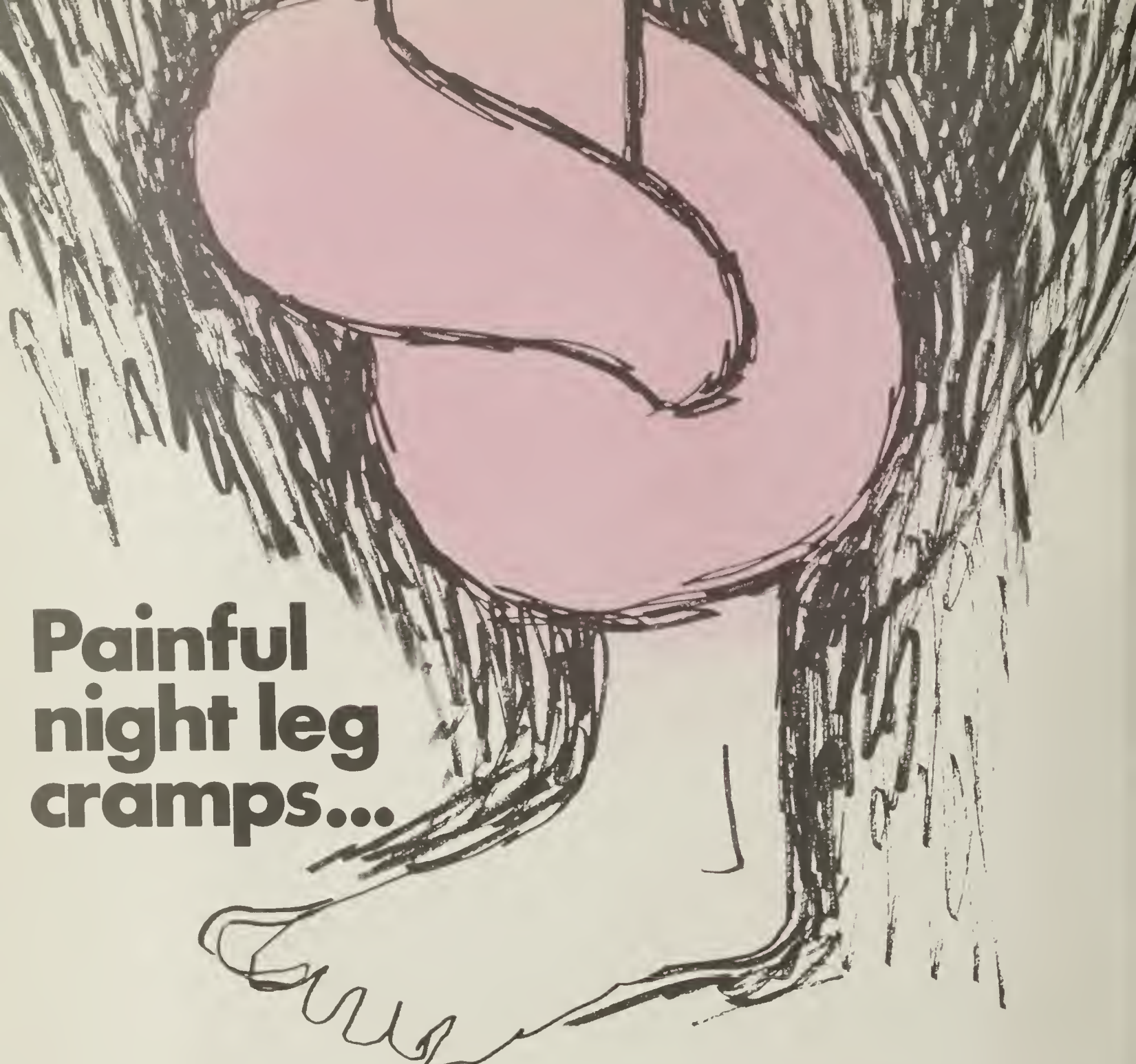
and jitteriness. In contrast, CNS depression has been reported. In a few epileptics, an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient—
including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
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PHILADELPHIA, PENNSYLVANIA 19144

QuinammTM
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

Councilor District Meetings Set

Eight PMS Councilor Districts have scheduled meetings from 3:00 p.m. to 5:00 p.m., October 5, 1970, during the 121st Annual Session of the Pennsylvania Medical Society at the Host Farm Resort Motel, Lancaster.

The councilor of each district extends a cordial invitation to all members of the county medical societies in his district to attend.

At these meetings, physicians will have an opportunity to discuss matters of importance that will be brought before the PMS House of Delegates, as well as other pertinent Councilor District business.

Meetings scheduled are as follows: District 2 — Monterey Room; District 3 — Eagle Room; District 4 — Bogey Room; District 5 — Parlor B; District 6 — Duffer's Room; District 7 — The Den; District 8 — Parlor C; District 11 — LaFonda Lounge; District 12 — Wood Room.

PENNSYLVANIA MEDICAL SOCIETY
ANNUAL SESSION



HOST FARM MOTEL, LANCASTER
OCTOBER 4-8, 1970

MD Has Role in Child Abuse Cases

In recent years the number of child abuse cases and fatalities has increased to the extent that it is becoming one of the most serious problems confronting the pediatrician and general practitioner caring for children, recent studies have shown.

National figures indicate that some 20,000 child abuse cases occur each year. Of these 5 per cent die, 10 per cent are removed temporarily or permanently from their homes after hospitalization or protective services are ordered and 25 to 30 per cent are injured permanently. The Pennsylvania Department of Public Welfare reports that in this state alone 586 child abuse cases and twenty-seven fatalities took place in 1969. The age group with the highest incident rate fluctuates between the one to two year group and the five to nine year group.

The parent abuser is most often the mother the survey indicated. The father and the step-father are also highly suspected. Abuse and neglect is not confined to a particular socioeconomic group, although it is more

frequently found in poor white areas than in other situations.

The warning signs of abuse are:

- (1) Frequent, poorly explained accidents
- (2) Burns, bites, bruises and black-and-blue marks
- (3) Poorly developed, lethargic infants
- (4) Depression, apathy, worry or fear
- (5) Death or serious illness resulting from prescribed medicine not being given.

The Family Physician's Role

The physician's responsibility is to both child and parent. The physician must work with constant awareness that 25 to 50 per cent of the children in such cases will either be dead or permanently injured in a year.

With colleague assistance the physician must diagnose, protect the child, counsel the parents, report his findings and follow-up the case medically and socially to assure that proper care is being taken.

The most common injuries encountered by the child are head injuries in the form of concussions and subdural hematomas, injuries to the large, long bones, and thoraco-abdominal injuries. Diseases such as scurvy, congenital syphilis, infantile cortical hyperostosis, osteogenesis imperfecta and diseases in which sensory deficits occur, as in meningomyelocele, are common in these children. Beyond physical injury the abused child often has the added problem of superimposed malnutrition, which can complicate therapy.

In view of the head and skeletal injuries frequently incurred and the age factor of abused children, it is not surprising that the frequency of developmental and mental retardation, and growth retardation is high. It has been found, however, that the correlation between abuse and developmental retardation is not necessarily causative, but one can assume that both the battering incidents and the poor developmental climate are in themselves symptoms of a third common factor, namely a personal deficiency in the parent.

To date there is very little that can be done for the child to prevent developmental retardation. Therapy has been carried out with some success on parents with provisions for parent models, birth control and medical consultation.

In a study reported in the June, 1970 issue of the Southern Medical Bulletin it was found that the majority of abusive parents appear normal outwardly. When tested however in the Minnesota Multiphasic Personality Inventory their scores for psychopathic deficiency and schizophrenic scales were four standard deviations above the mean. These high scorers exhibited tendencies toward impulsiveness, were unable to bind tension and were insensitive. Where the intelligence was high, an outward appearance of social conformity was easily maintained. But they were found to be suffering from ego deterioration, malignant breakdown of self-direction and feelings of isolation, worry and inferiority.



CONTINUING EDUCATION FOR PSYCHIATRISTS

Postgraduate Seminars for
Practicing Clinicians

Presented By

The Institute of the Pennsylvania Hospital in collaboration
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THERAPY OF PROBLEMS IN SEXUAL ADJUSTMENT

Martin Goldberg, M.D.; Harold I. Lief, M.D.; William L.
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FAMILY THERAPY

Jay Haley; Charles R. Koch, M.D.; Charles A. Malone,
M.D.; Salvador Minuchin, M.D.

MARITAL THERAPY

Philip M. Feldman, M.D.; Harold I. Lief, M.D.; David M.
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SEPTEMBER, 1970

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Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms.

Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney— rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth —dental staining (yellow-brown) in children of mothers given tetracycline

during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. **Average Adult Daily Dosage:** One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.



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The treatment of impotence

NEW
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in the American male is complex.
The concept of chemotherapy plus the
physician's psychological support is confirmed
as effective therapy.

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

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(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Contraindications: Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montazano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tittel, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, O. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.



Choice of 4 strengths:

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Each yellow tablet contains:

Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

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Each red tablet contains:

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Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
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Dose: 1 or 2 tablets daily.

Available:

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Android-Plus

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Each white tablet contains:

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Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
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Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.

Dose: 2 tablets daily.

Available: Bottles of 60, 500.

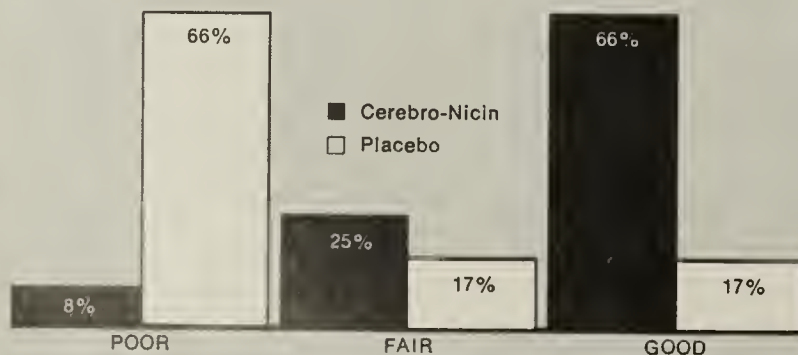
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc., June, 1964

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CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



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PENNSYLVANIA
MEDICINE

meetings

SEPTEMBER

1970 Scientific Assembly of the Medical Society of the District of Columbia, September 9-11, 1970, Washington Hilton Hotel, Washington, D.C.

Semiannual Meeting of the Medico and Chirurgical Faculty of Maryland, September 10-12, 1970, Hotel Hershey, Pa.

Eastern Pennsylvania Chapter, American College of Surgeons, Conference, September 10-11, 1970, Shawnee-on-Delaware, Pa. Contact Harry G. Light, M.D., Secretary, 65 E. Elizabeth Ave., Bethlehem, Pa. 18018.

Conference on Rural Health, September 18, 1970, Penn Harris Motor Inn, Camp Hill, Pa. Contact the Advisory Committee on Rural Health, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa.

American Medical Association Council on Occupational Health 30th Annual Congress on Occupational Health, September 29-October 1, 1970, Century Plaza Hotel, Avenue of the Stars, Los Angeles, Calif. 90067. Make direct hotel reservation contact.

OCTOBER

American College of Chest Physicians Second Fall Scientific Assembly, October 25-29, 1970, Century Plaza Hotel, Los Angeles, Calif., Contact Alfred Soffer, M.D., 112 E. Chestnut Street, Chicago, Ill. 60611

American Academy of Pediatrics 39th Annual Meeting, October 17-22, 1970, San Francisco, Calif.

Pennsylvania Medical Society 1970 Annual Business Session, October 4-8, 1970, Host Farm Resort Motel, Lancaster.

American College of Surgeons 56th Annual Clinical Congress, October 12-16, 1970, Chicago, Illinois.

American Heart Association Council for High Blood Pressure Research, "Hypertension, 1970", October 20-21, 1970, McClellan Hall, Jefferson Medical College, Philadelphia, Pa.

NOVEMBER

Pennsylvania Medical Society Annual Scientific Assembly, November 16-19, 1970, Host Farm Resort Motel, Lancaster.

American Heart Association 43rd Scientific Sessions, November 12-15, 1970, Atlantic City Convention Hall, Atlantic City, New Jersey.

American Heart Association Annual Assembly, November 16-17, 1970, Shelburne-Dennis Hotels, Atlantic City, New Jersey.

American Heart Association 24th Annual Meeting Council on Arteriosclerosis American Society for the Study of Arteriosclerosis, November 10-11, 1970, Howard Johnson's Motor Lodge, Atlantic City, New Jersey.

SEPTEMBER, 1970

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Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

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○ **W. Newton Long**, York; University of Pennsylvania, 1915; age 79; died April 8, 1970. He served in the Navy during World War I and in World War II served as medical adviser to the local selective service board. He was a specialist in internal medicine. His wife survives.

Joseph A. Baglivo, Philadelphia; Temple University School of Medicine, 1927; age 70, died February 26, 1970. A private physician for over forty years, he also served as physician for the Philadelphia Public Health Department, Sealtest Foods, Pioneer Paper Stock Co., and F. W. Woolworth Co. He is survived by his wife, a daughter and two brothers.

Mary L. Curtis, Pittsburgh; Howard University College of Medicine, 1926; age 68, died February 28, 1970. No survivors are listed.

John H. Kinter, Chambersburg; Jefferson Medical College, 1907; age 89, died March 2, 1970. He was a Spanish-American War veteran and during World War I was an examining physician for the draft board of Franklin County. He was also a former Franklin County coroner. A son survives.

Donald E. Jacobi, San Francisco, Cal.; University of Michigan School of Medicine, 1957; age 36, died March 10, 1970. No survivors are listed.

Joseph I. Levy, Philadelphia; Medico-Chirurgical College, 1912; age 79, died March 30, 1970. He practiced for more than fifty years and during that time also served as a Pennsylvania State Athletic Commission examiner. He was a former associate vice-president of the Philadelphia County Medical Society. Survivors include a daughter and two sons, one Jules Levy, M.D.

Ralph W. Maio, Levittown; Hahnemann Medical School, 1938; age 57, died January 16, 1970. His wife survives.

Joseph J. Mullen, Harrisburg; Temple University School of Medicine, 1926; age 68, died April 11, 1970. He had been a medical consultant to the State Department of Welfare and was

a diplomat of the American Board of Urology. Survivors include his wife, a brother and two sisters.

Arthur W. Pense, Whitehall; Queens University Faculty of Medicine, Ontario, 1923; age 70, died January 13, 1970. No survivors are listed.

○ **John B. Barrett**, Newcastle; University of Pittsburgh School of Medicine, 1929; age 64, died April 23, 1970. During World War II he served as a transport surgeon in the Navy. Two daughters, a son, a brother and three sisters survive.

○ **Mary R. Bowman**, Mt. Joy; Woman's College of Pennsylvania, 1907; age 88, died May 8, 1970. Survivors include nieces and nephews.

○ **Chapin Carpenter**, Wayne; University of Pennsylvania School of Medicine, 1916; age 79, died May 11, 1970. No survivors are listed.

○ **C. Melvin Coon**, Milan; College of Physicians and Surgeons, 1903; age 94, died April 30, 1970. Dr. Coon had served as president and treasurer of the Bradford Medical Association for many years during his fifty years of practice. He is survived by two daughters and a sister.

○ **Edward C. Edgerton**, Reading; Temple University School of Medicine, 1927; age 71, died May 13, 1970. He was a former president of the Berks County Medical Society and had recently been re-elected to the board of directors of Capital Blue Cross. His wife and daughter survive.

○ **John E. Eichholtz**, Philadelphia; University of Pennsylvania School of Medicine, 1937; age 66, died May 16, 1970. He was a former president of the Philadelphia Association for Psychoanalysis. His special interest was in the analysis of children. Survivors include his wife, two daughters and a son.

○ **Sheldon H. Kluger**, Kingston; Columbia University College of Physicians and Surgeons, 1948; age 46, died May 6, 1970. He was chief of pediatrics at the Wyoming Valley Hospital and at Wilkes-Barre General Hospital. Surviving are his wife, four sons, a daughter and a brother.

○ **George Konnick**, Shickshinny; Boston University School of Medicine, 1946; age 49, died May 19, 1970. His wife survives.

○ **Edward E. Koonce**, Ottsville; University of Pennsylvania School of Medicine, 1931; age 66, died April 27, 1970. He is survived by his wife, two daughters, a brother and a sister.

○ **Wellington A. Lebkicher**, Wernersville; University of Pennsylvania School of Medicine, 1913; age 79, died May 17, 1970. He was a former president of the Reading Hospital directing staff and of the Berks County Medical Society. No survivors are listed.

○ **John J. McCague**, Pittsburgh; University of Pittsburgh School of Medicine, 1924; age 73, died May 8, 1970. Surviving are his wife, three sons, one of whom is John J. McCague, Jr., M.D., and a daughter.

○ **Job F. Menges**, Ephrata; Temple University School of Medicine, 1931; age 67, died May 1, 1970. He was a former chief of gynecology at Reading Hospital and chief of obstetrics at Ephrata Community Hospital. His wife, two sons, one of whom is Job F. Menges, Jr., M.D., and two daughters survive.

○ **Saul Steinberg**, Norristown; Jefferson Medical College, 1931; age 63, died April 18, 1970. He was a well-known psychiatrist who had authored several medical papers and contributed to *Psychiatry in a Troubled World* by William C. Menninger, M.D. He was a former president of the Montgomery County Medical Society. Surviving are his wife, a son, a daughter, two brothers and two sisters.

○ **Marshall Stump**, Reading; Medico-Chirurgical, 1902; age 94, died May 16, 1970. A daughter survives.

○ **Louis D. Sulman**, Philadelphia; Medico-Chirurgical, 1912; age 80, died May 8, 1970. He was an internationally known specialist in disorders of the ear, nose and throat. He was a pioneer in the research on nasal decongestants and inhalers. He is survived by his wife, two daughters, three brothers and a sister.



CARDIOVASCULAR DISEASE

September 9-11, 1970; Philadelphia

C/AMA—MECHANISMS AND THERAPY OF CARDIAC ARRHYTHMIAS; by Hahnemann and American College of Cardiology; at Marriott Motor Hotel; 8 hrs. ea. day; fee: \$100 for members of Amer. College of Cardiology — \$125 for non-members. Contact Leonard S. Dreifus, M.D., Prg. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

May 6-7, 1971; Pittsburgh

C—PRE-INFARCTION PATIENT; by Pa. Heart Assoc.; at Chatham Center; 7 hrs. ea. day; 14 hrs. AAGP credit applied for; \$25 fee. Contact Royce J. Britton, Prg. Dir., Pa. Heart Assoc., P. O. Box 2435, Harrisburg 17105.

CHEST DISEASES

September 28—October 9, 1970; Wilkes-Barre V. A. Hosp.

November 30—December 11, 1970; Philadelphia (Hahnemann)

O/AMA—A WORKSHOP IN RESPIRATORY INTENSIVE CARE; by Greater Delaware Valley Regional Medical Program; 10 consecutive days; 8 hrs. ea. day; max. registration—15; 80 hrs. AAGP credit applied for. Contact R. F. Johnston, M.D., Head, Sect. of Chest Diseases, Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 3-14, 1970 and March 1-12, 1971; Philadelphia

PG—POSTGRADUATE COURSES IN BRONCHOESOPHAGOLOGY; at Temple. Contact Charles M. Norris, M.D., Chwälier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

November 11, 1970; Franklin

C/AMA—CURRENT CONCEPTS OF DIABETES MELLITUS; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 10, 1971; Sharon

C/AMA—MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

September 30, 1970; St. Vincent's Hosp., Erie

October 6, 1970; Host Farm Resort Motel, Lancaster

CODE KEY

C — Consecutive days

I — Intermittent

O — Circuit

PG — Postgraduate Traineeship

S — Designed for full-time specialists

AMA—AMA Accredited Institution

CES — Council on Education and Science, Pennsylvania Medical Society

CME — Committee on Medical Education

Hahnemann — Hahnemann Medical College and Hospital

Hershey — Milton S. Hershey Medical Center

Jefferson — Jefferson Medical College of Philadelphia

Penn-Grad — University of Pennsylvania, Division of Graduate Medicine

Pitt — University of Pittsburgh School of Medicine

Pitt P.H. — University of Pittsburgh Graduate School of Public Health

Penn State — Pennsylvania State University

Temple — Temple University Health Sciences Center

U. of Pa. — University of Pennsylvania School of Medicine

Woman's — The Medical College of Philadelphia

November 1970; Philadelphia County Medical Society

March 1971; Berks Co. Med. Soc., Reading

April 14, 1971; William Penn Hotel, Pittsburgh

May 1971; Conemaugh Valley Mem. Hosp., Johnstown

June 1971; Sacred Heart Hosp., Allentown

O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit \$5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

September, 1970; Philadelphia

PG—ACUTE CARE MEDICINE FELLOWSHIPS (retraining program for women physicians); by Med. College of Pa.; 6 hrs. per day; usual duration — 1 yr. Contact Ethel Weinberg, M.D., Assoc. Dean, Woman's, 3300 Henry Ave., Philadelphia 19129.

September 20-25, 1970; Pittsburgh

C—IMMUNOLOGICAL SEMINAR (10th Annual Postgraduate Course in Diseases due to Immune Mechanisms); by Pitt and Oakland VA Hospital. Contact Leo H. Criepp, M.D., Course Dir., Sect. on Clin. Immunology & Allergy, VA Hosp., University Drive C, Pittsburgh 15240.

October 29-31, 1970; Champion

I/AMA—MEDICAL RETREAT (variety of provocative medical subjects); by Jeffer-

son and Conemaugh Valley Mem. Hosp. (Johnstown); at Seven Springs Resort Hotel; 18 hrs. AAGP credit requested; \$45 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 16-19, 1970; Lancaster

C—CLINICAL THERAPEUTICS 1970: EMERGENCY MEDICINE (1970 Scientific Assembly of PMS); by CES; at Host Farm Resort Motel. Contact Robert L. Evans, M.D., CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

December 7-11, 1970; Philadelphia

C/AMA—EMERGENCY ROOM CARE (1 Physicians); by Hahnemann; at Marriott Motor Hotel; 25 hrs. AAGP credit applied for; \$125 fee. Contact Wilbur W. Oaks, M.D., Prg. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 3, 1971; Harrisburg

C—DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

INTERNAL MEDICINE

October 26-28, 1970; Philadelphia

C/AMA—NEW CONCEPTS IN BASIC AND APPLIED HEMATOLOGY; by Amer. Coll. of Physicians; at Jefferson; min. registration 50; max. registration 150; \$80 fee for ACP members (\$125 non-members). Contact Edward C. Rosenow, Jr., M.D., Exec. Dir., Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

MALIGNANT DISEASE

November 16-19, 1970; Philadelphia

C/AMA—CANCER CHEMOTHERAPY (2nd Symposium) by Hahnemann; at Sheraton Hotel; 26 hrs. AAGP credit applied for; \$125 fee. Contact Isadore Brodsky, M.D., Prg. Dir., Hahnemann; 230 N. Broad St., Philadelphia 19102.

OBSTETRICS & GYNECOLOGY

October 30, 1970; Darby

C/AMA—MENSTRUAL DYSFUNCTION; by Jefferson and Mercy Catholic Med. Center; \$20 fee. Contact J. Edward Lynch, M.D., Mercy Catholic Med. Center, Darby 19023.

December 3 and 4, 1970; Philadelphia

C/AMA—OFFICE GYNECOLOGY; two-day seminar; by Jefferson; at McClellan Hall; \$40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1971; Hershey Motor Lodge

C-12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; \$10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

PEDIATRICS

September 18-20, 1970; Hershey Motor Lodge

C/S-PROBLEMS OF THE PERINATE AND HEALTH SERVICES TO ALL CHILDREN; by Pa. Chap. of Amer. Acad. of Pediatrics. Contact James J. Reilly, M.D., 3520 Laketon Road, Pittsburgh 15235.

November 4-6, 1970; Children's Hosp. of Philadelphia

C-RESPIRATORY FAILURE IN INFANTS AND CHILDREN; by Amer. Acad. of Pediatrics, U. of Pa. and Children's Hosp.; 20 hrs. Contact Leonard Bachman, M.D., Course Coordinator, Children's Hosp., 1740 Bainbridge St., Philadelphia 19146.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park

C-SPORTS MEDICINE CONFERENCE; by CES and Penn State. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.

Altoona Hospital; fourth Thurs. ea. mo.
Greensburg (Westmoreland Hosp.); first Tues. ea. mo.

Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.

Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.

Uniontown Hospital; last Mon. ea. mo.

Washington Hospital; first Wed. ea. mo.

O/I-DIAGNOSIS AND MANAGEMENT

OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970-May 5, 1971

I-TEAM APPROACH TO PATIENT CARE (Fall-Winter Educational Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for.

Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970-May 20, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970-May 20, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970-May 20, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

DuBois Hospital; February 4-April 8, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970-April 17, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970-May 13-14, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12-April 21, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazleton State Gen. Hosp.; September 2, 1970-May 26, 1971

I-CONTINUING MEDICAL EDUCATION PROGRAM; by Hazleton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazleton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970-May 25, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster Gen. Hosp.; September 22, 1970-May 18, 1971

I-CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17602.

Lebanon; November 3, 1970-May 4, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10-April 14, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact C.M.E., Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970-May 5, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970-May 5, 1971

I-CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970-May 17, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

lough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14—December 2, 1970

I—RECENT ADVANCES IN MEDICINE; at Temple; 1 day ea. week; 32 hrs. AAGP credit applied for; \$50 fee. Contact Albert J. Finestone, M.D., Clin. Prof. of Med, Temple, 3400 N. Broad St., Philadelphia 19140.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grand View Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educa-

tional and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 hrs. AAGP credit applied for. \$35 fee (\$5 single session). Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CME, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS-

CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for; \$25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September—November, 1970 and February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 10 weeks ea. semester; 40 hrs. AAGP credit applied for; \$25 fee ea. semester. Contact J. Martin Myers, MD., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September 24—December 3, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; every Thurs.; 10 weeks; 20 hrs. AAGP credit requested. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Norristown; September—November, 1970

I—THE PRE-SCHOOL CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics; 2 hrs. ea. day; 1 day ea. week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hrs. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia, 19139.

Philadelphia; September 30—December 2, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 20 hrs. AAGP credit requested; \$75 fee. Contact

Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 6—December 15, 1970

I/S—BEHAVIOR THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Hosp. of U. of Pa.; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8—December 24, 1970

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF ALCOHOLISM, DRUG ADDICTION AND SEXUAL PROBLEMS; at The Institute of Pennsylvania Hospital; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970—April 6, 1971

I—MEDICAL HYPNOSIS; by The Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; \$150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 12—December 14, 1970

I/S—FAMILY THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Phila. Child Guidance Clinic; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13—December 15, 1970

I/S—MARITAL THERAPY; by The Insti-

tute of the Pennsylvania Hosp. and U. of Pa.; at the Phila. Marriage Council; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 14, 1970—March 3, 1971

I/AMA—PSYCHIATRIC PROBLEMS OF CHILDREN; at Hahnemann; every Wed. (except holidays); 18 weeks; 36 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. of Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; \$75 fee for 10-week session, \$150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 26—December 14, 1970

I/S—THERAPY OF PROBLEMS IN SEXUAL ADJUSTMENT; by The Institute of Pennsylvania Hospital and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 7—March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS; at The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin

Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February—April, 1971

I/S—TREATING SEXUAL INADEQUACY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March—April, 1971

I/S—PSYCHOPHARMACOLOGY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. ea. day; 1 day a week; 8 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March—May, 1971

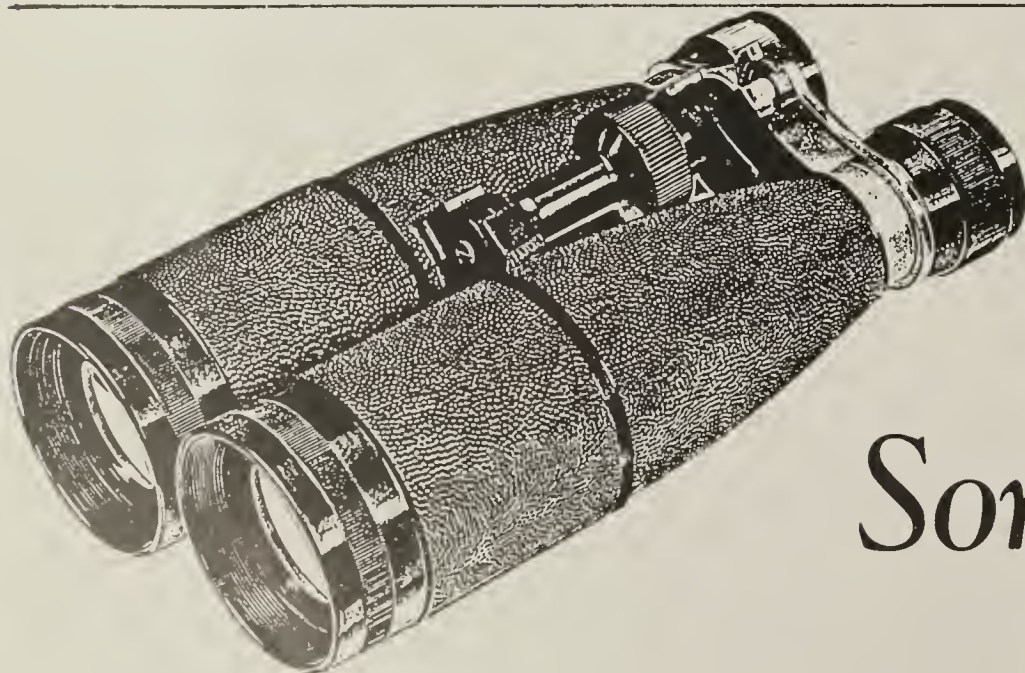
I/S—DRUG ABUSE AND ACUTE PSYCHOSIS; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 24—May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; April 7—May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; \$50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.



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Psychiatrists and physicians—Accredited hospital; approved psychiatric residency program, affiliated with approved general hospital. \$17,839 to \$25,115; housing possible. Pennsylvania license required. R. L. Gatski, M.D., Director, State Hospital, Danville, Pennsylvania 17821.

House Physicians (two)—Immediate opening for a 208-bed J.C.A.H. approved hospital. Positions open for day and evening shifts. Must have a Pennsylvania license. Salary \$15,000. Apply to Mr. E. F. Mallon, Jr., Asst.

Administrator, Sacred Heart General Hospital, Chester, Pa. 19013.

Urgently needed: General Practitioner, fully accredited hospital; 70 beds, construction for new wing late summer. Contact Administrator, Community Hospital, Kane, Pa.

Residency—Child Psychiatry—(two years) Academically and analytically oriented. 1,000 bed general hospital. Individual supervision given. Director and supervisors certified in child psychiatry and child psychoanalysis. Training built on knowledge of normal development through observations and on extensive individual diagnosis and therapeutic experience with full range childhood problems. Through integrated affiliations, work with psychosis, mentally defective, and organically damaged children and also work in school system and comprehensive pediatric program. Opportunity for research. Close proximity psychoanalytic training facilities. Five weekly conferences. Salary \$7,000 to \$12,000+ depending on year. Opportunities for additional stipends available. Apply Irwin Lyons, M.D., Director of Training, Child Psychiatry, Albert Einstein Medical Center, York & Tabor Roads, Philadelphia, Pennsylvania 19141.

Psychiatrist with training and experience in Child and Adolescent Psychiatry for an adolescent unit with an in-patient census of 25 patients. Duties will include the full range of psychi-

atric services to adolescent patients and their families. Close community contact is involved. Opportunities for establishing a private practice and private consulting work. Foreign graduates must have the ECFMG Certificate. Pennsylvania medical license required. Liberal vacation and sick leave benefits. Salary \$19,664 to \$25,115, dependent on experience. Apply to: Personnel Officer, Harrisburg State Hospital, Pouch A, Harrisburg, Pennsylvania 17105. The Commonwealth of Pennsylvania is an equal opportunity employer.

Emergency room physician—full time; Accredited 300 bed general hospital; active approved internship and residency programs; excellent benefits. Submit resume to: Administrator, Robert Packer Hospital, Sayre, Pa. 18840.

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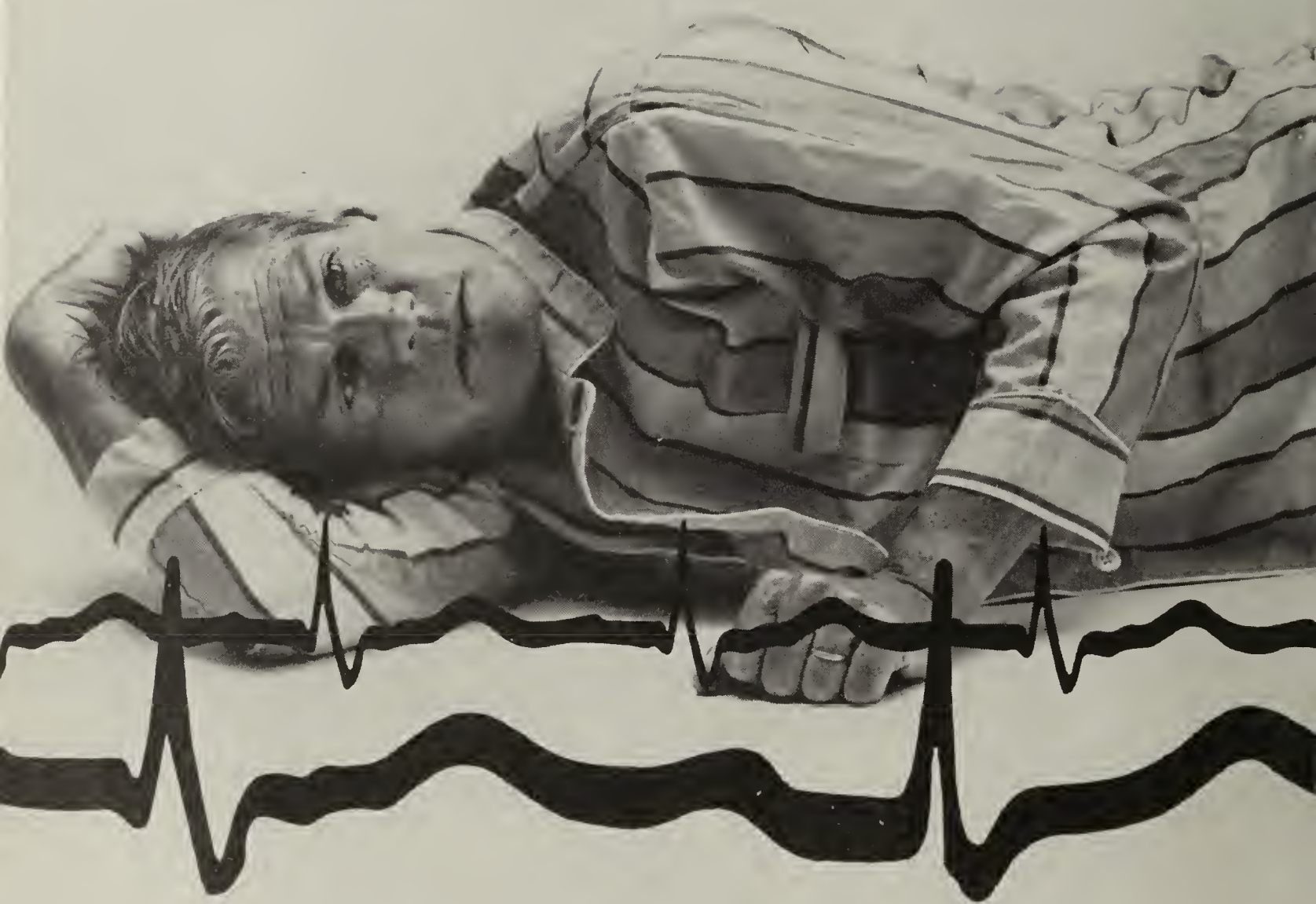
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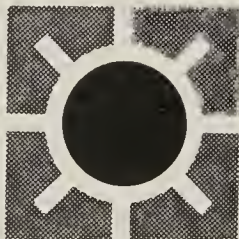
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O	9 - 12:00 noon	Specialty Program:	Pa. Chapter, Amer. Acad. of Pediatrics
N	1:30 - 4 p.m.	Specialty Program:	Pa. Acad., Phys. Med. & Rehabilitation
D	2 - 4 p.m.	Specialty Program:	Pa. Allergy Assn.
A	2 - 5 p.m.	Specialty Program:	Pa. Soc., Intern. Med. & Amer. Coll. Phys.
Y	2 - 5 p.m.	Nurses Seminar:	Cardiac and/or Pulmonary Emergencies

T	9 - 1 p.m.	PMS Seminar:	Continuing Medical Education
U	9 - 11:45 a.m.	Nurses Workshops:	Career Ladder; Changing Role of Nurses;
E	10 - 12 noon	Specialty Program:	Midwifery; Continuing Education
S	1:30 - 3:30 p.m.	Specialty Program:	Pa. Assn., Clinical Pathologists
D			Pa. Sect., Dist. III, Amer. Coll.,
A	2 - 5 p.m.	Specialty Program:	Obstetricians & Gynecologists
Y	2 - 5 p.m.	Education Workshops:	Amer. Cancer Soc., Pa. & Phila. Divisions
			Evaluating Quality, Role of RMP & OHP,
			Medical College Affiliations
	2 - 5 p.m.	Nurses Seminar:	Genetic Counselling; Abortion Laws

W	9 - 12 noon	PMS Seminar:	Gastrointestinal Emergencies
E	9 - 11:45 a.m.	Nurses Workshops:	Ostomy Care; Endocrinology
D	All Day *	Specialty Program:	Pa. Psychiatric Society *
N	1 - 5 p.m.	Specialty Program:	Pa. Soc., Colon & Rectal Surgery
E	2 - 4 p.m.	Specialty Program:	Urological Assn. of Pa., Inc.
S	2 - 4 p.m.	Specialty Program:	Pa. Acad. Ophth. & Otolaryn.
D	2 - 4 p.m.	Nurses Seminar:	Team Approach to Gastrointestinal
A			Emergencies
Y			

T	9 - 12:30 p.m.,	PMS Seminar:	Diagnosis and Treatment of Acute and
H			Chronic Respiratory Problems
U	2 - 5 p.m.	Specialty Program:	Pa. Chapter, Amer. Coll. Chest Physicians
R			and
S			Pa. Thoracic Society
D	2 - 5 p.m.	Specialty Program:	Pa. Div., International Coll. of Surgs.
A			
Y			

* This meeting will be held at Host Corral (one block from Host Farm).
† These programs have been arranged for family practice physicians.

PENNSYLVANIA MEDICAL SOCIETY
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1970 Scientific Assembly

OCTOBER, 1970

BLUE SHIELD FOR CHIROPRACTORS STILL POSSIBLE

That ancient, battered, but never quite dead legislative proposal, Senate Bill 254, is on the final passage calendar of the House of Representatives. It is possible that it will be voted on after the House, now in recess for the political campaign and November 3 election, returns for the short session until the 154th Session of the General Assembly itself dies a natural death on November 30. If the bill is not acted on during that period, it dies with the session. Senate Bill 254 is almost as old as the current Legislature, the 153rd Session of which convened January 7, 1969. The bill to include chiropractors in the Blue Shield program was introduced early in the session, referred to the Senate Insurance Committee on February 25, 1969, reported out of committee on June 16 and was passed by the Senate on July 8, 1969 by a vote of 34 to 8. Then began its long and arduous trip through the legislative mazes of the House of Representatives. First it was referred to the Committee on Consumer Protection on July 9, 1969. On July 15, 1969, it was re-referred to the House Committee on Rules. On July 23, 1969, it was again re-referred, this time to the House Committee on Health and Welfare, where public hearings were held. That committee voted not to report the bill to the floor for action in February, 1970. Finally, in July of 1970, after adding restrictive amendments, the committee reluctantly reported the bill to the floor for action. The House defeated the bill by a vote of 102 to 83. A week later, by a voice vote, the "dead" bill was reconsidered and recommitted, this time for a second time to the House Rules Committee. The bill was placed on the final passage calendar of the House when the lawmakers returned following vacation recess. But just the night before recessing until after the election, the House "passed over" Senate Bill 254, thereby keeping it a live issue for the post-election session. It is quite conceivable that it will come up for a vote in its original form when the Legislature reconvenes. There is the remote possibility that the measure will die when the Legislature automatically adjourns November 30. Lawmakers will be home to campaign prior to the election. Every concerned voter can avail himself of the opportunity to discuss issues such as this with his representative.

AMA SUPPORTS ALCOHOLISM INSTITUTE

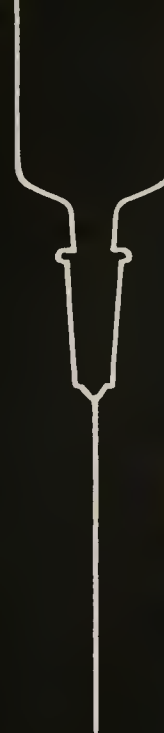
Senate Bill 3855, which would establish a national institute for the prevention and control of alcohol abuse and alcoholism and coordinate federal, state and local programs related to alcoholism was supported strongly September 17 by Herbert A. Raskin, M.D., a

member of the AMA Committee on Alcohol and Drug Dependence before a hearing on the bill by the House Interstate and Foreign Commerce Committee. Dr. Raskin said the bill is the first effort that has been made to determine as a matter of national policy that alcoholism is an illness and constitutes a major public health concern. Dr. Raskin spoke in Pennsylvania the last week in September at the Governor's Conference on Drug Abuse (see related story in Newsfronts).

AMA-PMS COOPERATE ON SEMINARS The AMA Council on Foods and Nutrition and the PMS Council on Education and Science are cooperating on a series of seminars on the medical sciences to be held in the 1970-71 academic year at colleges throughout the Commonwealth. "Research and Discovery in Medical Science" is the title of a speech to be presented at four colleges by Denis Abelson, M.D., associate professor of medicine at the University of Pennsylvania School of Medicine. "Nutrition and Brain Damage" is the topic of Lewis Barnes, M.D., chief of service in the department of pediatrics at the same school. He will speak at eight colleges. "Early Factors in Cellular Growth and Development" by Jerome Knittle, M.D., of New York, and "Environmental Factors in Chronic Disease and Aging" by Robert McGandy, M.D., Boston, will be presented at seven colleges. A complete listing will appear in the November issue of PENNSYLVANIA MEDICINE.

DR. ROTH RECOUNTS EVENTS OF VISIT Russell B. Roth, M.D., of Erie, speaker of the AMA House of Delegates, was one of five top medical leaders and government officials invited to tour Russian medical facilities last May. Accompanied by his wife, Dr. Roth made the trip, and tells the story on pages six and seven of the September 14 issue of American Medical News. Another of the top U.S. medical leaders who made the trip to study Russian medical care was Patrick Storey, M.D., of Hahnemann Medical College, Philadelphia.

PENNSYCARE SUBSTITUTE POSSIBLE A four-year old plan to replace Pennsycare with a health insurance program as the instrument to provide health care for the poor is being reconsidered by the Pennsylvania Department of Welfare. PMS President William A. Barrett, M.D., Pittsburgh, said the State Society has supported such a plan for two years because it would take recipients of state health care services out of the "second class citizen" category by removing any welfare identification. Department of Welfare consideration is still in very early stages, although a blanket invitation to insurance plans to submit bids was issued by Stanley Miller, department secretary.



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JOURNAL OF THE PENNSYLVANIA MEDICAL SOCIETY

OCTOBER, 1970

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On the front cover, William A. Limberger, M.D., West Chester, is shown swearing in the two immediate past presidents of the Pennsylvania Medical Society: John H. Harris, Sr., M.D., Harrisburg, and George E. Farrar, Jr., M.D., Philadelphia, and the current president, William A. Barrett, M.D., Pittsburgh. Dr. Limberger performed this duty as chairman of the Board of Trustees. Now it's his turn as president.

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

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Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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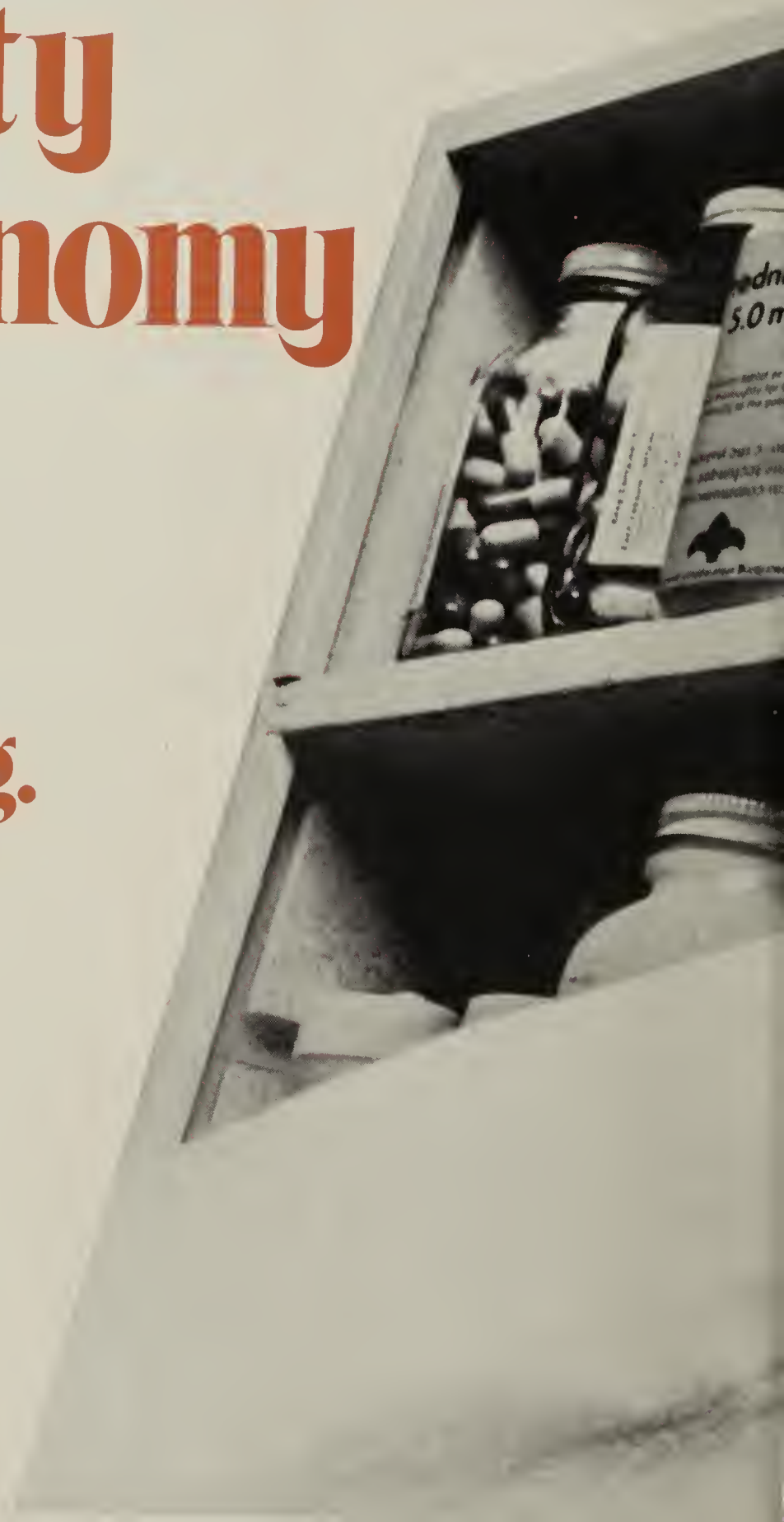
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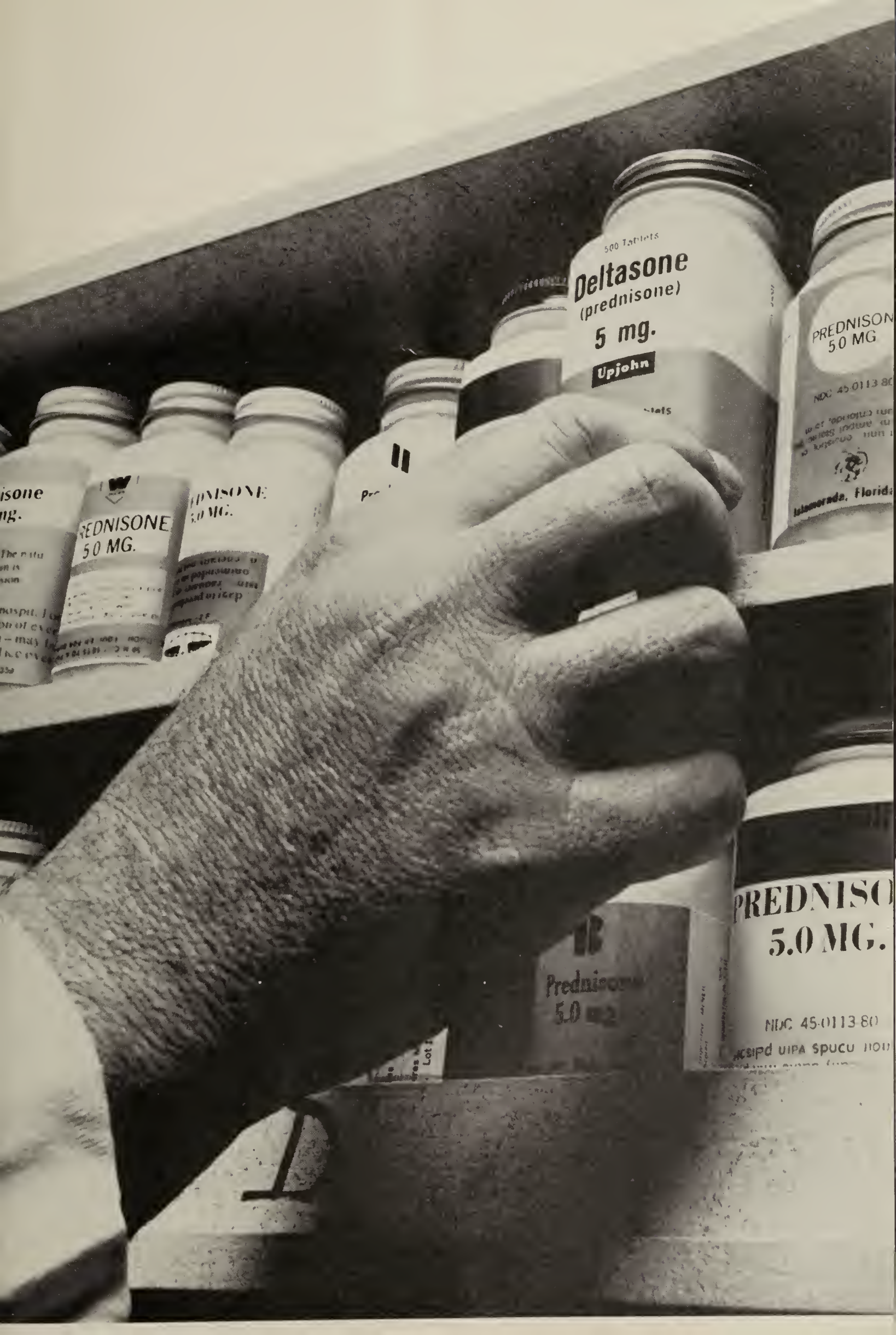
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

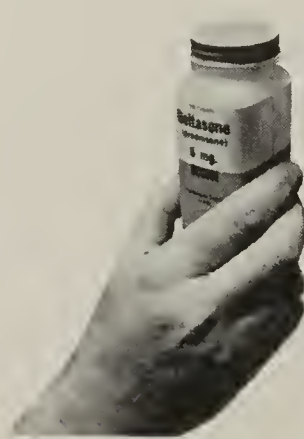
Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED 8-15 (KQ8-8)

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The Upjohn Company, Kalamazoo, Michigan 49001



Deltasone® 5 mg.
(prednisone, Upjohn)

**an economical
prednisone
that's made
a name for itself**

Dr. Limberger Assumes Presidential Duties

A West Chester newsboy, printer's devil, farmhand, shipyard rigger and now physician who was led into medicine by an attack of appendicitis becomes the president of the Pennsylvania Medical Society on October 6.

He is William A. Limberger, M.D., who still practices medicine in the house in which he was born and brought up by a widowed mother—at 301 S. Church St., West Chester.

On the evening of October 6 in Lancaster at the annual meeting of the Pennsylvania Medical Society House of Delegates, he will take the oath of office as president of the 12,000-member physician organization. He will succeed William A. Barrett, M.D., of Pittsburgh. The delegates then will choose a new president-elect who will take office a year from now.

A lot of things happened between the time Bill Limberger ran errands and poured molten lead in the composing room of the *West Chester Daily Local News* and the election of Dr. Limberger as president of the Pennsylvania Medical Society. One of his several newspaper jobs didn't naturally lead to a career in medicine. They and

a variety of other jobs were necessities because Bill largely has been making his own way in life since he was twelve.

His father, a native of Danville who came to West Chester at the age of twenty-five where he met and married a local girl, died of typhoid fever at the age of thirty-five and left a wife, five-year-old Bill and another three-year old son. Mrs. Limberger also cared for a semi-invalided mother. Thankfully, their house was large enough to enable Mrs. Limberger to take in roomers.

Farmland and Printer's Devil

Of necessity then, Bill started working as soon as possible. His first major job was as a farmhand. Throughout high school, he had three newspaper delivery routes—morning, evening and Sunday papers. Once he worked full-time for the *West Chester Daily Local News* as a utility man in the composing room—a job that is perhaps best described as “printer's devil.” Then came jobs as a trucker and rigger at a shipyard and an almost endless succession of part-time jobs in the long, hard scholastic drive to become a physician.



DR. LIMBERGER

Bill played high school football as a tackle—and played it well—until his senior year when an attack of appendicitis put him in the hospital. It was 1918—the midst of the flu epidemic—and in the hospital recovering from his operation, Bill Limberger resolved to work with the sick. Two weeks after he left it as a patient, he returned to the hospital as a volunteer worker in the men's ward where his purpose became



DR. LIMBERGER is shown above at State Society gatherings reflecting joviality, concentration, leadership and deep thought. Through the years he has assumed many roles of importance in organized medicine.

even more definite and specific—he wanted to be a physician.

How does a fatherless boy who has to earn his living finance the long, costly road to becoming a medical doctor? Bill says simply, “I managed.” Then when you check at Swarthmore College where he took his pre-med training, you find that he managed it on a scholarship and was a Phi Beta Kappa and that his scholarship average at Swarthmore won him a full scholarship at the University of Pennsylvania Medical School.

In his last year at Penn, he helped operate a medical clinic three nights a week at a settlement house in South Philadelphia where he met and fell in love with a social worker named Gladys Jackson. They were married during his internship. Interns received no pay then and duty left no time for part-time jobs. The Limbergers lived on what Gladys earned.

Internship completed, he and Gladys returned to West Chester to live with his mother while he served as an assistant to a respected specialist in internal medicine, Dr. Henry Pleasant, Jr. Three years later, he opened his own office in his mother's house.

War Duty in Europe

Then came World War II. Dr. Limberger joined the staff of a 1,200-bed Army hospital as assistant chief of medicine in 1942 and went with it to various places in North Africa and Italy. Then he took a course in psychiatry so that he might better handle the enormous load of battle fatigue cases that his hospital was receiving. Often, he was found in the front lines at battle surgical and first-aid stations. After three years of service, he was discharged as a Lieutenant Colonel and returned to West Chester to resume his specialty of internal medicine. He has been there ever since.

From the time he became a physician, Dr. Limberger has been active in medical organizations. He was president of the Chester County Medical Society in 1948 and nine years later became a delegate to the Pennsylvania Medical Society House of Delegates. That House elected him a member of the State Society Board of Trustees for two terms starting in 1961. He became chairman of the Board in 1966 and served until his election as president-elect of the State Society in October of last year. Throughout that time he has held a multitude of volunteer posts as a member of a

variety of medical groups on the local, state and national levels.

Active in Civic Affairs

Despite a very active practice and his involvement in medical organizations, he has been very much a part of community and civic affairs. In 1948, the West Chester Chamber of Commerce established a “Citizen of the Year” award and Bill was the first recipient. He's a past president of the local Lions Club and of the West Chester Civic Association, an Elder in the Presbyterian Church, chief of staff at the hospital and a member of its board of managers.

The Limbergers have two children—Bill, Jr. who is a veterinarian near West Chester and a daughter, Ann Louise Knorr, a music teacher in Pennsville, N. J. Bill and Gladys are grandparents five times over.

A hobby? Bill says he thinks most clearly while working with his hands in the soil of his vegetable garden—to the dismay of his wife who wishes he'd pay more attention to the flower beds.

Almost all of Bill's time will be taken up with the duties of the office of president of the State Society. He is concerned about having his patients go to other physicians. His decision to accept the presidency was a somewhat reluctant one, urged on him by dozens of colleagues from all over the state. There was no opposition. His election was by acclamation.

Looking back on a life far more varied than most, it is perhaps the measure of the man when Bill says that if he had everything to do all over again, he would do exactly the same things in the same way—including those triple newspaper routes and lugging heavy bars of lead in the newspaper composing room. □

Temple Expands Emergency Dept.

Formal dedication of the new, expanded Emergency Department at Temple University Hospital was held recently. The department, one of the most active in the city sees about 40,000 patients each year, the previous facilities could not adequately serve these North Philadelphia residents.

Only a year ago the residents complained about the lack of service, and with hospital representatives formed a joint committee to create an emergency department to serve the needs of residents requiring medical care.

Postgrad Institute Held In Phila.

Hundreds of physicians returned to classes September 24, when the Philadelphia County Medical Society held its thirty-fourth annual Postgraduate Institute.

Coronary heart disease, medical and surgical aspects of cancer, alcoholism and the venereal disease explosion were some of the major topics on which more than thirty medical experts lectured. Various physicians lectured during the morning and afternoon programs which were followed by panel discussions.

The three-day institute, which is one of the oldest locally-sponsored postgraduate programs, opened Thursday, September 24, at the society headquarters, 2100 Spring Garden St.

The program ended on Saturday with the Annual Pfahler Oration by William S. Blakemore, M.D., professor and chairman, Graduate Department of Surgery, University of Pennsylvania, School of Medicine. He spoke on “Surgical Treatment of Coronary Artery Disease.”

Physicians who attended the institute earned credit toward their postgraduate training requirements for the American Academy of General Practice.

AMA Convention To Be In Boston

The 24th Clinical Convention of the AMA will be held November 29 through December 2, 1970 in Boston, Mass. The convention this year will examine the expanding needs of the practicing physician.

The program has been planned by the Greater Boston medical community under the supervision of program director, Claude E. Welch, M.D. The scientific program is designed to serve both the general practitioner's and specialist's interests. There will be a series of lectures, discussion sessions, scientific and industrial exhibits, and motion pictures.

Included in the wide range of topics offered will be “Surgery of the Gastrointestinal Tract,” “Drug Treatment for Hyperkinetic Overactive Children and Children with Learning Difficulties,” “Coronary Heart Disease—One Team's Approach,” “Cerebral-Vascular Disease: New Concepts,” and “The Thyroid Nodule.”



Sandoz announces...

a new agent for
the alcohol-dependent patient
who wants to quit

and

a program for the Pennsylvania physician
who wants to help



When alcohol becomes a way of life



new **SERENTIL**[®] (mesoridazine)

a major tranquilizer with specific advantages for the alcohol-dependent patient:

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



a program for early recognition and successful treatment:

Alcoholism in Pennsylvania*

State Rank

total no. alcoholics	4th
no. per capita	12th
per capita consumption†	27th

Pennsylvania Physicians' Report (compared with U.S. average)

	%Pa.	%U.S.
see 5 or more problem drinkers in 2-month period	32.8	37.1
half or more seen are women	33.8	37.4
treat, rather than refer	72.7	72.6
more community services needed	62.8	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory**, a nationwide survey of treatment centers.

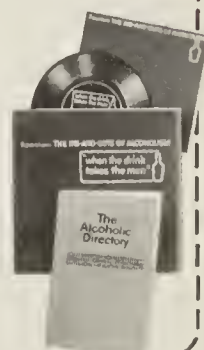
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See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

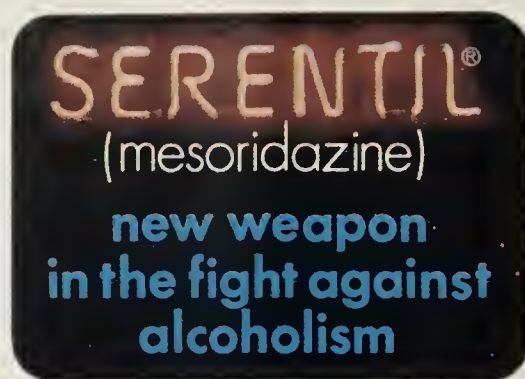
Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least 1/2 hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few



(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, onorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible.

There is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arrest, has been noted.

Extrapyramidal Symptoms: Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, akinesia—some of which on rare occasions have persisted for several months or years especially in patients of advanced age with brain damage.

Endocrine Disturbances: Menstrual irregularities, altered libido, gynecomastia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxical reaction have been reported. These include excitement, bizarre dreams, aggravation of psychoses and toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long-term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclera and cornea. Opacities of the anterior lens and cornea described as irregular or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dosage of Serentil (mesoridazine), as in most medications, should be adjusted to the needs of the individual. The lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to a maintenance level.

Alcoholism: For most patients the usual starting dose is 25 mg. b.i.d. The usual optimum total daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless of severity, a starting dose of 50 mg. t.i.d. is recommended. The usual optimum total daily dose range is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: For most patients a starting dose of 25 mg. t.i.d. is recommended. The usual optimum total daily dose range is 75-300 mg. per day.

Psychoneurotic Manifestations: For most patients the usual starting dose is 10 mg. t.i.d. The usual optimum total daily dose range is 30-150 mg. per day.

Injectable Form: In those situations in which an intramuscular form of medication is indicated, Serentil (mesoridazine) Injectable is available. For most patients a starting dose of 25 mg. is recommended. The dose may be repeated in 30 to 60 minutes, if necessary. The usual optimum total daily dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg., and 100 mg. mesoridazine (as the besylate). Bottles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besylate)]. Inactive ingredients—Disodium Edetate, U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg.; Carbon Dioxide Gas (Bone Dry), q.s.; Water for Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 100.

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J. 

The actions of the official
Tincture and Extract of
Belladonna result chiefly from
their Atropine content . . .
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL[®]

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains:
Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED

Tablet in bottles of
100, 500 and 5000
Capsule in bottles
of 100, 500 and 1000

Caution: Federal law prohibits
dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

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Roche
announces

Efudex[®]

(fluorouracil)
cream/solution

for the treatment
of solar/actinic keratoses...
a topical alternative
to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche[®] (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex[®] (fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream
Applied twice daily—resolves
solar or actinic keratoses.

new
Efudex[®]
(fluorouracil)
cream/solution



For full prescribing information, please see the following page.

Roche
introduces



(fluorouracil)
cream/solution
the new standardized topical
for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (e.g., CO₂, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ¹⁴C-labeled Efudex demonstrated insignificant absorption as measured by ¹⁴C content of plasma, urine and respiratory CO₂.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local

reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.



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of colds and flu**

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aspirin**

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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Subsidiary of Sterling Drug Inc.

MEASURIN[®]
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.

The treatment of impotence

in the American male is complex.
The concept of chemotherapy plus the
physician's psychological support is confirmed
as effective therapy.

NEW
CLINICAL
STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android[®]

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Keto-steroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensary (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

REFER TO
PDR

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (1/3 gr.) . . 30 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

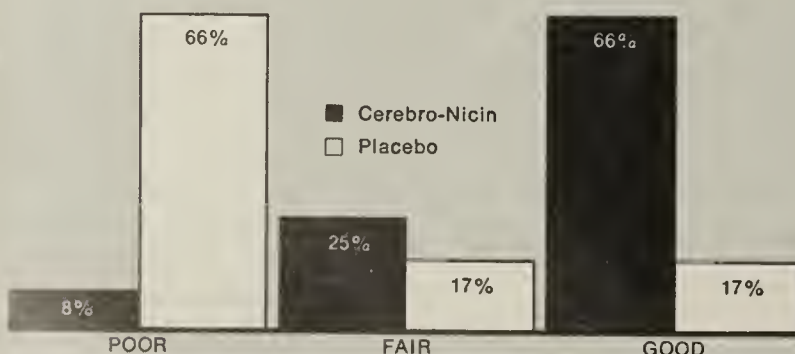
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A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC.

For the treatment of the aging patient

Cerebro-Nicin[®]

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN[®] New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
1-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine 3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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PDR

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Write for Product Catalog



"TESTIMONY UNLIMITED" might have been the title for a summer theme song of the State Society. Representatives testified in Washington and Harrisburg, as well as other locations, at a variety of hearings. Recorded photographically as well as verbally for the official record were the following PMS officers presenting State Society views: Top left is President William A. Barrett, M.D., who appeared before the House Committee on Health and Welfare to testify on the proposed merging of all health and welfare agencies in a Department of Human Services. In the middle photograph on the left Dr. Barrett is shown testifying before the Republican Platform Committee in Pittsburgh. At the bottom left, John H. Harris, Jr., M.D., Carlisle, chairman of the Council on Governmental Relations, presents testimony in opposition to the Pennsylvania Health Agency proposal. He appeared before the House Consumer Protection Committee in Harrisburg. At the bottom right, President-Elect William A. Limberger, M.D., West Chester, listens to other testimony at a meeting of the State Government Task Force on Human Services. He presented the Society's position regarding the establishment of a Department of Human Services at that meeting.

decision:



Loridine® I.M.

Cephaloridine

1.5 to 3 Gm. daily
successfully treats many
moderately severe
infections*

- bactericidal action in vitro against susceptible organisms causing:
 - pneumonia
 - urinary tract infections
 - septicemia
 - abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations *Before Administration of Loridine*

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



000903



Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

Additional information
available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206



Rinehimer Heads Pennsylvania Blue Shield

Robert E. Rinehimer, of Camp Hill, has been named president of Pennsylvania Blue Shield, the largest of seventy-two such health care financing plans in the United States. He succeeds Matthew K. Gale who retired following twenty-four years of service.

Rinehimer, a native of Wilkes-Barre, has been senior vice-president of the plan since January, 1967. He joined Blue Shield in 1954 as administrative assistant to the executive vice-president. Rinehimer was named a vice-president in 1956.



MR. RINEHIMER

He attended public schools in Wilkes-Barre, was graduated summa cum laude from Lafayette College, Easton, in 1938, and was elected to Phi Beta Kappa. He has done graduate work at the Universities of Pennsylvania, Michigan and Syracuse.

Rinehimer served in the U.S. Navy during World War II and the Korean conflict and was discharged with the rank of lieutenant commander after serving a total of nine years.

Prior to his employment at Blue Shield, Rinehimer was head of the English department at the Mining and Mechanical Preparatory School in Freeland, Pa., served as program and educational director of the Wilkes-Barre YMCA, and was director of admissions and registrar at Keystone Junior College, LaPlume, Pa.

He is a member of the Board of Directors of the National Association of Blue Shield Plans and is a member of that group's planning and study committee. He previously served as

chairman of the association's enrollment committee.

Gale will continue to serve Blue Shield as a member of the board of directors and also as a member of the board of Medical Indemnity of America, Inc., Chicago, Ill.

Cancer Research Grants Awarded

American Cancer Society research and education grants totaling over \$168,000 have been awarded to six Philadelphia medical centers. They are Children's Hospital, Drexel University, Hahnemann Medical College, the Medical College of Pennsylvania, Philadelphia College of Osteopathy and Wills Eye Hospital.

The grants are allocated by the American Cancer Society's national office by a board of independent scientists. They are in effect throughout the U. S. and are supported by funds from all fifty-eight divisions of the society in an amount exceeding \$21 million annually.



THE Lay Advisory Committee of the Pennsylvania Medical Society, which is scheduled to meet again October 21, held its organizational meeting recently. Shown above, standing left to right, are Patrick M. Greene, Harrisburg, and Senator John H. Ware, Oxford. Seated are George L. Cullen, Philadelphia, who was selected chairman of the committee, and PMS President-Elect William A. Limberger, M.D.

Industrial Health Meet Set

Miles O. Colwell, M.D., Pittsburgh, will be the opening speaker at the 35th Annual Meeting of the Industrial Health Foundation, Inc., (IHF) to be held October 13-14, 1970 at Chatham Center, Pittsburgh. Dr. Colwell is vice president of the Aluminum Company of America and vice-chairman of IHF's Board of Trustees.

IHF is a non-profit research and

education association for the advancement of health conservation management and healthful working conditions in industry. Robert T.P. DeTreville, M.D., president of IHF indicated that IHF desires "to help insure scientific objectivity and genuine health protection and conservation in the interest of the work force."

TB In Steady Ten-Year Decline

The Pennsylvania Department of Health recently indicated that there has been a steady decline in the number of active tuberculosis cases in the state since 1961.

The average rate of decline has been 5.7 per cent. Of these the highest rate of occurrence has been in non-white males and the lowest rate in white females. Harrisburg and Johnstown report the highest case rates of TB in 1968 for cities of their size.

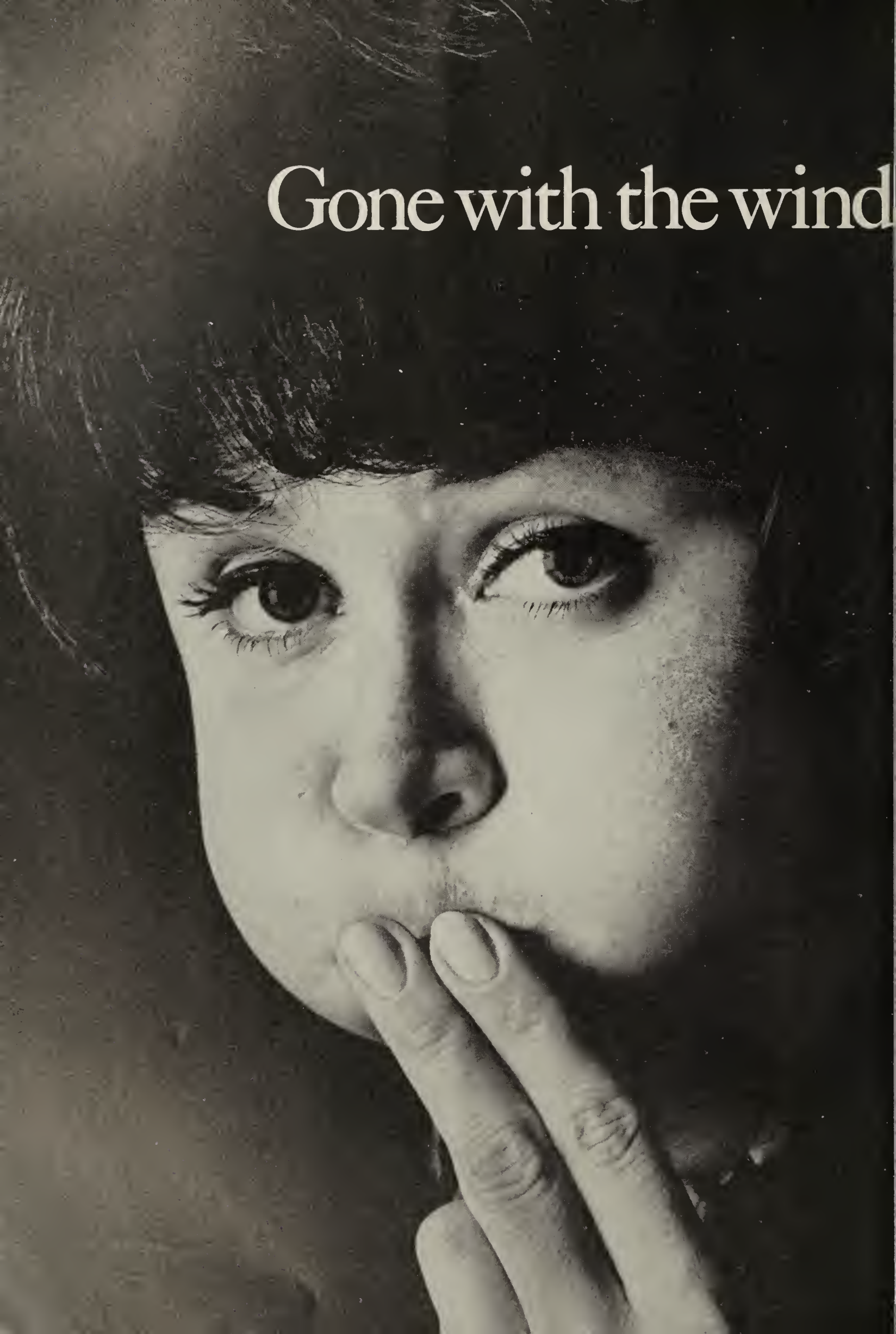
Oscar B. Griggs, director of the Division of Chronic Respiratory Diseases feels that with continued prompt treatment and detection of the disease

the number of cases and deaths will continue to decrease.

Utilization Project Given Government Contract

The Hospital Utilization Project of Pittsburgh has been given a nineteen month, \$174,500 contract with the United States Public Health Service to develop and implement a nationwide utilization review training institute. Gerald J. Sector, M.D., of the University of Pittsburgh's Graduate School of Public Health will be the institute's director.

Gone with the wind



The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with — in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in:
gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity •
gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifoethicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

one dose does both: frees captured gas...neutralizes free acid



Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **SIDE EFFECTS:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening. **SUPPLIED:** Bottles of 100 and 500.

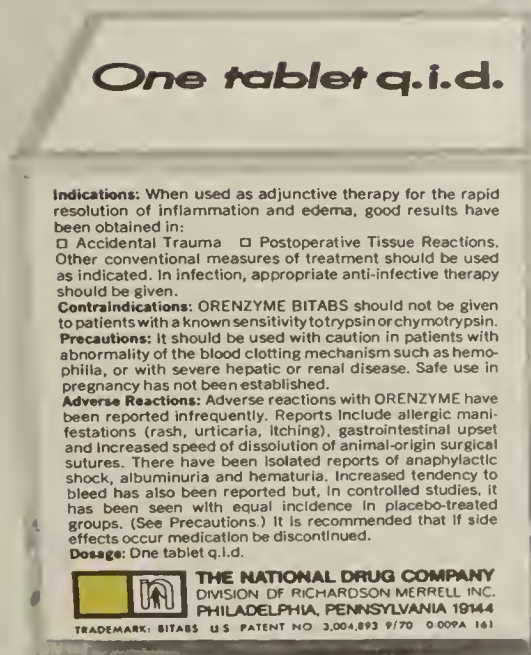
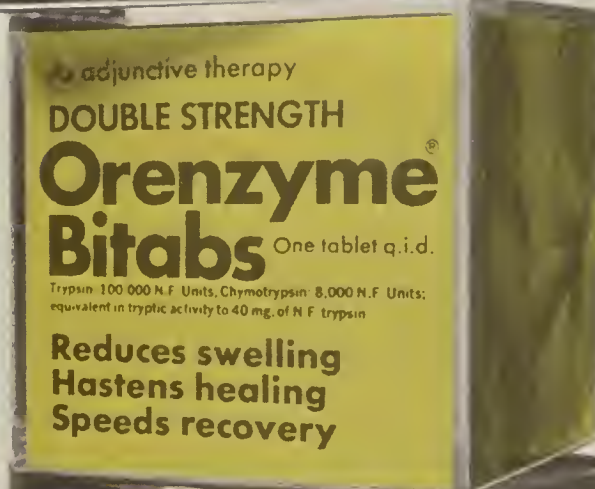
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Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

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Orenzyme[®] Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple



Trichomonads...monilia...bacteria

You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC

Cream (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

TRADEMARK: AVC AV-007A 7/70 Y.149



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AVC

The treatment is singular

Dr. Gloeckner Named 'Distinguished Daughter'

Louise C. Gloeckner, M.D., of Conshohocken, the "first lady" of organized medicine in the state and perhaps the nation, has been named by Governor Raymond P. Shafer as a "Distinguished Daughter of Pennsylvania." The announcement was made by the Governor's office on September 27 and the presentation ceremonies will take place at the Governor's Mansion in Harrisburg on Wednesday, October 7.

Dr. Gloeckner has just completed a term as vice-president of the Amer-

ican Medical Association, the first woman to hold the office.

"Her dozens of offices and honors in medical organizations would lead one to wonder how she has found, the time for them, and yet such activity is subsidiary to her roles as a wife, mother, family physician, church leader and civic-minded citizen.

"In the past year, she has represented the medical profession at various international meetings. A colleague in a letter to members of the AMA House of Delegates last year described her as: '...A soft-spoken, informed champion whose ideals will not bend under stress, a lady who speaks out on vital issues in a way that often reminds us of the voice of our own consciences...'

"What a fitting description. Her record of dedication shows how very much it is deserved."

PMC Planning Institute On Studies In Sexuality

The works of Masters and Johnson, homosexuality, women's liberation impotence and frigidity, will be the topics under discussion at the fourth annual symposium on the psychodynamic implications of the various physiological studies to be held at the Eastern Pennsylvania Psychiatric Institute on November 16. This year's symposium, entitled "The Psychodynamic Implications of Physiological Studies in Sexuality," is sponsored by the department of psychiatry and neurology, of the Medical College of Pennsylvania. It will begin at 9 a.m. and continue throughout the day.

Leo Madow, M.D., professor and chairman of the MCP department of psychiatry and neurology, will serve as moderator for a panel of experts, each of whom will present a thirty-minute paper which will then be discussed by the entire panel. Time permitting, the discussion will be opened to the audience.

Among the speakers will be Paul J. Fink, M.D., associate professor of psychiatry at Hahnemann Medical College, who will discuss the "Implications of Recent Physiological Studies on the Problems of Impotence and Frigidity." Dr. Fink conducted a symposium on sexuality which has been published



THE LAWRENCE COUNTY Medical Society met September 1, and had as guest speaker William A. Limberger, M.D., PMS president-elect. Left to right above are Dr. Limberger, Jack C. W. Brooks, M.D., secretary, and Gerald Zieve, M.D., president of the Lawrence County Medical Society.



DR. GLOECKNER

ican Medical Association, the first woman to hold the office and is currently a member of the AMA's Council on Constitution and Bylaws. She was a member of the Pennsylvania Medical Society and AMA House of Delegates for a number of years and has held a multitude of key positions in the county, state and national levels of organized medicine, including a vice-presidency of the Pennsylvania Medical Society.

Dr. Gloeckner was nominated for the "Distinguished Daughter" honors by the Pennsylvania Medical Society and the Commonwealth's selection committee was unanimous in their choice of her.

Six other women are to be similarly honored at the ceremonies. In announcing the selection of Dr. Gloeckner, Governor Shafer released a citation that reads in part as follows:

"Few women have achieved such outstanding recognition in her profession. Medical bodies of her county, state and nation have honored her with elevation to officer status. She has

under the title, "Sexual Function and Disfunction."

The symposium is open to all interested physicians, medical students, and mental health workers. There is no charge.

Further information may be obtained by contacting Dr. Madow at VI9-0400, extension 4436.

Malpractice Meet In Pittsburgh

A Medical Malpractice Seminar sponsored by the Pittsburgh Institute of Legal Medicine, Duquesne University School of Law and the American College of Legal Medicine will be held November 20 and 21 at Duquesne. Among the topics under consideration will be legal standards of care in medical diagnosis and treatment, evaluation and preparation of malpractice cases involving drug companies, pre-trial discoveries of medical malpractice cases and the role of the trial judge in evaluating new legal theories in malpractice cases.

For further information contact: Cyril H. Wecht, M.D., J.D., Allegheny County Coroner, 542 Fourth Avenue, Pittsburgh, 15219.

Berks And Lancaster Test Autotutor

A self-teaching machine called the autotutor is becoming very popular for physicians seeking a convenient form of continued education. The autotutor is currently available in the Lancaster and Reading areas through the cooperation of the respective county medical societies and Wyeth Laboratories. In Lancaster the machine is in the Lancaster General Hospital and will be available for use there until March. The Community General Hospital, Reading, currently has the autotutor at its disposal until November 1, when it will be moved to the Reading Hospital for

two months. During January and February it will be available at St. Joseph's Hospital.

The autotutor was developed by Wyeth Laboratories with the aim of providing physicians with a convenient, efficient and effective continuing education program. The six basic programs which have been made available are: office gynecology, treatment of thyroid disorders, diabetes control, liver function tests, dermatology, and alcoholism. These programs vary in length from one to six hours and are recorded on microfilm. Information is given and

multiple choice questions based on the information follow. The physician indicates his answer by pressing a response button. If he is correct the machine automatically moves on to the next phase. Should the wrong answer be chosen the machine presents material to correct the error.

This method of continuing education was tried and found useful at the American Academy of General Practice (AAGP) annual meeting.

AAGP and ACGP (American College of General Practitioners in Osteopathic Medicine and Surgery) credit has been applied for.

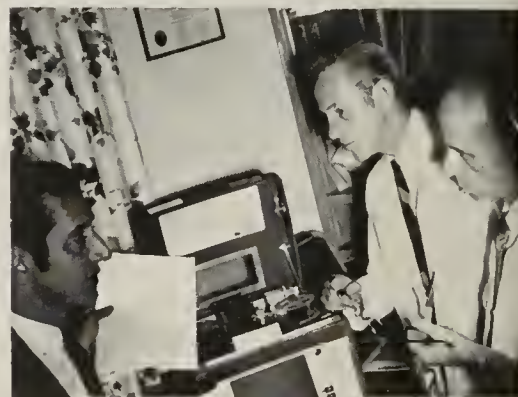
Pollution Meet Set

"Transportation and Its Impact on Pollution" is the theme of a two-day conference of the Mid-Atlantic States Section of the Air Pollution Control Association to be held October 8 and 9 at the Penn-Harris Motor Inn, Camp Hill.

William P. Lear, Sr., of Reno, Nev., who has been working several years to develop a steam engine for automobiles which would meet modern demands for performance without contamination of the air, will be a featured speaker.



LANCASTER General Hospital's director of medical education, John H. Esbenshade, M.D., above left, and Jack Rothstein, representative of Wyeth Laboratories, center, discuss the capabilities of the autotutor as a hospital library assistant looks on. To the right, pictured left to right, are Mr. Rothstein explaining the functions of the autotutor to J. F. Welsh, M.D., and C. N. Wang, M.D., at Community General Hospital, Reading.



York Hospital In Eleventh Year Of Post-Grad Classes

York Hospital began its eleventh year of a series of weekly post-graduate seminars on September 17 through April 29, 1971. These programs of continuing education are designed to keep physicians informed of the most recent medical advancements and scientific developments.

The seminars, sponsored by York Hospital, Jefferson Medical College, and Pennsylvania State University, will be held in the auditorium of the Marie Ketterman Student Nurses Residence, York Hospital, beginning at 9:30 a.m. and continuing until noon.

Early this year, York Hospital be-

came the first and only community hospital in the nation to receive the "Physicians Recognition Award for Continuing Education" from the American Medical Association. This was the first time an entire staff had met the prescribed standards of continuing education for physicians.

"I think this is a tribute for our medical staff, for setting standards as well as maintaining these standards over the years," said Dr. Robert L. Evans, vice-president of Medical Affairs. "Our physician minimum standards are much higher than the standards set by the American Medical Association."

Dr. Evans is a member of the PMS Council on Education and Science.

Approximately 100 physicians from the area attend each seminar. "The objective of the annual medical seminars is to promote the transfer of newer knowledge and general clinical concepts from medical research and teaching centers to practicing physicians. An equally important aim is to present material that will have practical usefulness in the office and at the bedside, and to encourage a free interchange of ideas among those persons who attend the seminars," he said.

Frozen Kidney Thawed, Reimplanted

A laboratory dog whose kidney was removed, frozen, thawed, and successfully reimplanted, could be the hero of the decade.

According to a description of the successful surgery first cited in *Medical World News*, a professional medical journal, the experiment was conducted by Herndon B. Lehr, M.D., director of the division of plastic surgery at the University of Pennsylvania School of Medicine. "We were about to give up on the kidneys after twelve years of failure," Dr. Lehr said. "For years, we couldn't get anything that even looked like a kidney after freezing and thawing. This is our first success; it began to put out urine three weeks after reimplantation."

The kidney produces about an ounce of urine over a two-hour period. This is not a lot, admits the researcher, but it is of good quality.

In a similar experiment recently conducted at the Cleveland Clinic, researchers removed and preserved unfrozen kidneys for twenty-four hours before reimplantation. They found that the reimplanted kidney soon regained function comparable to the remaining kidney with no detrimental effects upon the health of the animal.

See the related scientific article, "A Viable Organ Bank," on page 57. Dr. Lehr is one of the five authors.

Hahnemann To Run Health Center

A \$629,000, eight month health services contract between the Spring Garden Community Service Center (SGCSC) and Hahnemann Medical College and Hospital was made recently. The contract agreement makes provisions for health services for 13,000 inner-city residents in the Spring Garden area.

Medical services for the community have been provided by Hahnemann's department of community medicine since the opening of the SGCSC in 1968. Under the new contract the SGCSC will assume responsibility for supervision and health care delivery services.

The primary objective of the community is to establish comprehensive family oriented care through efficient in-patient, home and rehabilitation services.

Dial Access Program From Sayre Is Popular, Survey Of M.D.'s Shows

Physicians like the new medical information by telephone service instituted at Robert Packer Hospital, Sayre, by the Central New York Regional Medical Program last winter, according to a recent survey.

The unique form of continuing education allows a doctor to call a special telephone number and request to hear four to six-minute tapes on medical subjects free of charge.

The service, known as Dial Access, began by offering eighty different mini-lectures. It has been expanded since to provide 120 tapes on medical subjects.

"The survey indicates that we have met our primary objective of providing current information of immediate use to practicing physicians dealing with specific clinical problems," according to Paul C. Royce, M.D., director of medical education at Robert Packer Hospital and Dial Access project director. "All the doctors queried felt that the information on the tapes was 'worth the time it took to call.'"

Questionnaires were mailed to 90 doctors and 68, or 76 per cent were returned. "The response alone was short of spectacular," Dr. Royce said, "and certainly most encouraging. All of the doctors said that they listened to the entire tape. A total of 88 per cent said they called to gain specific information, 6 per cent indicated the problem was an emergency and 67 per cent said that they specifically made use of the information." Dial Access is avail-

able toll-free to physicians in Pennsylvania area codes 717 and 215. Doctors outside these areas must pay the regular toll charge. Bradford and Susquehanna Counties in Pennsylvania are part of the area served by the Central New York RMP.

A revised list of available lectures and the phone numbers is being mailed to physicians. Additional information may be obtained by contacting the Central New York Regional Medical Program, 750 East Adams Street, Syracuse, N. Y. 13210, or the Dial Access Project, Robert Packer Hospital, Sayre, Pa. 18840.

Dr. Rowland Speaks On 'Harrisburg Report'

George A. Rowland, M.D., Millville, was featured on a recent WITF "Harrisburg Report" discussing reform of the state abortion law. He was interviewed by Bill Diebler of the *Pittsburgh Post-Gazette*, John Feeley of the *Norris-*



DR. ROWLAND

town *Times-Herald*, and Karl Abraham of the *Philadelphia Bulletin*.

Dr. Rowland is a family physician and member of the Pennsylvania Medical Society's Board of Trustees. He is also an alternate delegate from Pennsylvania to the American Medical Association, and editor of the *Columbia County Medical Society Bulletin*.

Drug Abuse Meet Draws Over 500

The Governor's Conference on Drug Abuse, which drew some 500 field leaders from throughout the Commonwealth, was held September 23 and 24 at the Penn-Harris Motor Inn, Camp Hill.

Among the speakers were Emil Trellis, M.D., of Western Pennsylvania Psychiatric Institute, Pittsburgh; and Herbert A. Raskin, M.D., member of the AMA Committee on Alcoholism and Drug Abuse.

BREAKUP — symbol of the impact of emotional stress. But when the stress exceeds transient rage or depression — and settles into a chronic mixed anxiety depression state — combined tranquilizer-antidepressant therapy could be indicated.





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WITH COEXISTING
DEPRESSION

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ANTIDEPRESSANT

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TRIAVIL[®]4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as

its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Rural Health Conference Successful

William A. Barrett, M.D., president, Pennsylvania Medical Society, welcomed an audience of more than 150 people to the Rural Health Conference sponsored by the PMS, September 18, at the Penn-Harris Motor Inn, Camp Hill.



DR. HESS

Katherine B. Hess, M.D., advisor to the drug control program of the Pennsylvania Department of Health, presented a luncheon address on drug abuse. Other speakers at the all-day conference are shown in the photo at the right.

Others who participated were: Mrs. Kenneth Bostwick, North East; Ward M. Stover, Indiana; and Ernest J. Witte, V.M.D., Harrisburg. Bond L. Bible, Ph.D., of the Council on Rural Health, American Medical Association, gave the summation.



SPEAKERS at the morning session of the Pennsylvania Conference on Rural Health held September 18 at the Penn-Harris Motor Inn were, left to right, Arthur D. Nelson, M.D., Philadelphia; Charles J. H. Kraft, M.D., Meshoppen; Donald E. Harrop, M.D., Phoenixville; and J. Mostyn Davis, M.D., Shamokin.

Blue Shield Names New Officials

Pennsylvania Blue Shield has expanded its executive staff to meet the increasing needs of the 7.5 million Pennsylvanians it serves.

President Robert E. Rinehimer announced the appointment of three executive vice presidents replacing a single senior vice president and named seven new vice presidents, each heading a division of Blue Shield business.

The new executive vice presidents and their areas of responsibility are:

William E. Keller, Harrisburg, government programs; Leroy K. Mann, Grantham, administration; and Sydney E. Sinclair, M.D., Williamsport, operations.

The new vice presidents and their divisions are:

Carl Bonfils, Mechanicsburg, Medicare; Robert J. Horst, York Haven RD 1, actuary; Bruce L. Huntzinger, Harrisburg, controller; Ivor H. Jones, New Cumberland, administrative services; Arthur P. Keiser, Harrisburg, sales; Norman Tuck, Camp Hill, professional relations; and Ronald J. Venet, Mechanicsburg, utilization review.

The number of claims Blue Shield has received for processing has tripled in the past four years to about 6 million annually. To handle the increased volume, Blue Shield's work force has more than doubled since 1966.

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The United Way!*



THE PENNSYLVANIA Medical Golfing Association's first place award, The Blue Shield Senior Trophy was presented to P. Joseph Andrews, M.D., (left) by PMGA president John Manges, M.D., at a dinner following the tournament at the Hershey Country Club on August 11. Frank Burns, M.D., (right) received the second place McKee Cup and C. William Weissner, M.D., (not pictured) received the Blue Shield Handicap Trophy for third place.



Malnutrition Linked To Retardation

Severe malnutrition of either the mother, the baby while in early stages of development or both, is a suspected cause of mental retardation.

The thesis is based on the results of laboratory animal and human studies presented at a recent meeting of the Canadian Pediatric Society by Myron Winick, M.D., professor of pediatrics at Cornell University, which "...provide new and more conclusive evidence that severe pre- and postnatal malnutrition may inhibit division of cells in the growing brain."

Animal studies showed that if malnourishment is experienced during a period of fetal cell division, there is a permanent deficit in the number of brain cells as high as 15 per cent. If an animal is severely malnourished both pre- and postnatally, there may be as high as 60 per cent reduction in the number of cells in the brain when brain cell division stops. The duration of the malnutrition as well as the severity and exact time is important in determining the total number of cells that will develop in the brain.

In humans the same principles seem to apply. A study of severely malnourished Chilean children, both of those who are alive and those who have died, indicates similar results. The dead children's brain size had also been reduced due to an inhibition of cell division. Head size was also reported to be reduced proportionally. Those children who survived showed retardation of their motor and intellectual development.

Another recent report by the National Research Council says that high incidences of low birth weights and of deaths connected with low weight are found in the United States, which ranked thirteenth among forty countries in 1966 in infant mortality. The birth weight of an infant is strongly associated with and conditioned by the weight gain of its mother as well as her pre-pregnancy weight and stature. Age of the mother and the number of children she has had are also important factors for determining the outcome of pregnancy. Fetal loss and infant mortality are especially high among girls under 17 years of age, particularly those who have had repeated short-interval conceptions.

An adequate diet, not just during pregnancy but from the mother's own

birth through growth and reproduction is of utmost importance for both the mother and her baby.

Surveys of human experiences during World War II and in lesser developed nations more recently have indicated that restriction of diet during pregnancy may unfavorably affect the growth and development of the fetus. In addition,

laboratory experiments on dogs, sheep and other animals show a marked reduction in the size of the offspring when the mother is maintained on an inadequate diet.

Environmental factors which may relate to malnutrition seem to be especially prevalent in lower socioeconomic levels.

Nutrition And Aging Are Subjects Of Philadelphia Conference

The Philadelphia Geriatric Center and the Committee on Nutrition, Metabolism and Endocrinology of the Philadelphia County Medical Society will sponsor an all-day conference entitled "Hyperglycemia and Nutrition in the Aged." The meeting will be held at the Philadelphia Geriatric Center on

November 4, and will include addresses by Jonathan E. Rhoads, M.D., president of the Philadelphia County Medical Society, who will deliver the Michael G. Wohl memorial lecture on "Nutritional Aspects of Diabetes in the Elderly," and T. S. Danowski, M.D., of Pittsburgh, who will present "Criteria for Diagnosis of Diabetes."



A CHAPTER DEVELOPMENT PROGRAM was held September 19 at the Penn-Harris Motor Inn, Camp Hill by the Pennsylvania Association of Medical Assistants, an organization of physician's office assistants from throughout the state. Workshops on county membership, education, programs and ways and means were conducted. H. Robert Davis, M.D., Boiling Springs, spoke on the public relations aspects of associations. Shown above is a group of the officers and committee chairmen who arranged the conference.

Jefferson To Study Hemophilia

A one-year contract for over \$25,000 has been given to Thomas Jefferson University's Cardeza Foundation for Hematologic Research by the Pennsylvania Department of Health's Division on Maternal and Child Health.

The funds will be used for the production of Anti-Hemophilic Globulin (Factor VIII), or cryoprecipitate concentrate, so that Pennsylvania's he-

mophiliacs under 21 may receive treatment.

Production and dispensing of the blood clotting concentrate is under the direction of Edward R. Burka, M.D., Philadelphia, the director of the blood bank, and Sandor S. Shapiro, M.D., Merion, director of the hemophilia clinic.

The Children's Hospital of Philadelphia recently announced that Frederick Becker, M.D., was appointed associate administrator for medical affairs. His duties will include administrative coordination for all medical and dental training programs at the hospital and direct administrative supervision to numerous professional departments.

Peter Randall, M.D., professor of plastic surgery at the University of Pennsylvania School of Medicine, has assumed the post of chief of the Department of Plastic and Reconstructive Surgery at Lankenau Hospital. He succeeds Hans May, M.D. He is also surgeon at Children's Hospital, consultant in plastic surgery at the VA Hospital, Philadelphia Naval Hospital, Magee Memorial and the Home of the Merciful Saviour for Crippled Children.

John A. Dattoli, M.D., Camp Hill, has been appointed regional medical director for the state health department's south-central Pennsylvania region. Dr. Dattoli formerly headed the department's Division of Alcoholism Studies and Rehabilitation.

Daniel C. Braun, M.D., formerly assistant medical director of the United States Steel Corporation, has joined the Industrial Health Foundation, Inc. as its manager of Occupational Medicine Services. Dr. Braun is also a lecturer in occupational health at the University of Pittsburgh's Graduate School of Public Health.



DR. BRAUN DR. PRENDERGAST

York hospital recently announced changes in its medical staff. Kenneth E. Wilt, M.D., has been named chairman of the department of surgery and Michael J. Prendergrast, M.D., a urologist at the Brockie Medical Center in York, has joined the hospital's medical staff.

Glen R. Leymaster, M.D., Villanova, has relinquished his post as president of the Medical College of Pennsylvania to join the staff of the American Medical Association in Chicago. Marion Spencer Fay, Ph.D., is acting-president of the Medical College. Dr. Fay was president and dean from 1959 until 1963 when she went into retirement.

Errol D. Henriques, M.D., Ebensburg, has been elected to membership in the American Academy of General Practice (AAGP). Founded in 1947, the AAGP is the country's second largest national medical association, with more than 31,000 family physician members.



DR. SHAFFER

George W. Shaffer, M.D., of Blooming Glen, recently accepted a position with the National Institutes of Health in Washington, D. C. At the institute, which is the nation's major medical research center, Dr. Shaffer will serve as assistant chief of Employee Health Services. This is a new position which calls for development and coordination of preventive medicine programs.

Dr. Shaffer has served the Pennridge area as a physician for almost twenty years. In that time he has been president of the Bucks County Medical Society, and has held positions in the Pennsylvania Medical Society and the Pennsylvania Medical Political Action Committee. He is also a member of the Bucks County Board of Health.

Henry S. Schutta, M.D., Philadelphia, a Pennsylvania Hospital neurologist, has been invited to discuss his research findings at the Second International Congress on Mental Retardation in Warsaw, Poland and at the International Congress on Neuropathology, in Paris. His topics of discussion in Warsaw will be, "Finestructure Studies on Human and Experimental Kernicterus" and "Electron Microscopic Observations on the Central and Peripheral Nervous System in Canine Globoid Leucodystroph." In Paris his presentation will deal with "Morphologic Observations on the Peripheral Nerves in Canine Krabbe's Disease."

David Cornfeld, M.D., director of the outpatient department of Children's Hospital of Philadelphia, will serve a second term as president of the hospital's medical staff.

James H. Gault, M.D., a specialist in the diagnosis of cardiovascular disease has been appointed associate professor of medicine at the Milton S. Hershey Medical Center. He was formerly chief of the cardiovascular diagnosis laboratory and assistant professor of medicine at the University of California School of Medicine at San Diego.

Jerome A. Hubscher, M.D., Haverstown, has been named associate clinical research director at the Squibb Institute for Medical Research.

Morris Kramer, M.D., Easton has been elected a fellow in the American College of Cardiology. This group consists of accredited and certified specialists in diseases of the heart and blood vessels. Its purpose is to encourage continuing education and training of such specialists.

Alan B. Gruskin, M.D., and Iain F. S. Black, M.D., of St. Christopher's Hospital, Philadelphia, have been awarded a two-year grant by the National Heart and Lung Institute of the National Institute of Health to study how blood entering the kidneys of children is distributed within the kidneys. They hope to further define abnormalities of kidney function already described in children with congenital heart disease and to become more efficient in combating kidney disease.

(Continued on Page 40)

What is worth doing..



In 1936 A. E. Smith, professional at Woolcombe, England, recorded the lowest golf score for an 18 hole course. He shot 55 and was 15 under par. The course at Woolcombe, which measured 4,248 yards was covered in 4, 2, 3, 4, 2, 4, 3, 4, 3 out and 2, 3, 3, 3, 3, 2, 5, 4, 1 in.

s worth doing well.

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Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms.

Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney— rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth —dental staining (yellow-brown) in children of mothers given tetracycline

during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. **Average Adult Daily Dosage:** One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Leroy A. Rodgers, M.D., Portage, was recently elected president of the Cambria County Chapter, American Academy of General Practice.

It was announced recently that Jack Sabloff, M.D., New Cumberland, was appointed director of the Bureau of Field Services for the Pennsylvania Department of Health. Formerly he was of the department's Children's Cardiac Section in the Division of Maternal and Child Health. Gordon W. Allen, M.D., succeeds Dr. Sabloff as acting director of the division.

Robert E. Dye, M.D., and Elaine Eyster Dye, M.D., are a husband and wife team of internists recently appointed assistant professors of medicine at the Milton S. Hershey Medical Center, Hershey.

Paul C. Royce, M.D., director of medical education at Robert Packer Hospital, has been elected to the Royal Society of Health. The society, founded in 1876, brings together men and women throughout the world from all professions concerned with health.

For the first time in the ninety-six year history of the Hospital of the University of Pennsylvania a woman, Helen L. Mits, M.D., has been appointed chief medical resident. She will supervise thirty-seven residents and twenty-six interns.

Oscar B. Griggs, M.D., has been appointed director of the Pennsylvania Health Department's Division of Chronic Respiratory Diseases. Since 1965 he has served with the division as chief of Diagnostic and Clinical Services. The division operates tuberculosis hospitals in Philadelphia and Pittsburgh and maintains seventy-four TB clinics throughout the state.

Bernard L. Segal, M.D., Philadelphia, was recently appointed to the board of trustees of the American College of Cardiology and to the editorial board of the *American Journal of Cardiology*.

The 1970 Joseph Goldberger Award in Clinical Nutrition is being presented jointly to Jonathan E. Rhoads, M.D., D.Sc., and Stanley J. Dudrik, M.D., of the University of Pennsylvania School of Medicine. The award is presented to them for their "outstanding contributions to the nutritional management of the surgical patient and for pioneering research using intravenous hyperalimentation."



DEDICATING a new plaque to the memory of physicians and dentists who served Philadelphia State Hospital at Byberry are, from left to right: Abram Persky, M.D., of Philadelphia, vice-president of the hospital's medical committee; George Given, M.D., of Bustleton, committee president; and Daniel Blain, M.D., of Germantown, director. Through the efforts of its staff, volunteers, and the community, the hospital population has been reduced to 2,855 patients.

C. James Favino, M.D., a pathologist and Joseph A. Weader, M.D., a pediatrician have recently joined the medical staff at Geisinger Medical Center in Danville.

Frank H. Gardner, M.D., has been appointed director of medicine at Presbyterian-University of Pennsylvania Medical Center. He has served as acting director for the past ten months and director of the Hematology Research Laboratory at the medical center prior to that.

Hershel E. Griffin, M.D., dean of the University of Pittsburgh's Graduate School of Public Health and professor of epidemiology, was elected to membership on the American Board of Preventative Medicine. The board participates in inspection and approval of all residency training programs in four fields of preventative medicine and examines and certifies physicians in public health, aerospace medicine, occupational medicine and general preventative medicine.

Edward M. Whalen, M.D., Kingston, has been named a fellow of the Pennsylvania Psychiatric Society. He has been a diplomate of the American Board of Psychiatry since 1959.

Milton Freiwald, M.D., FICS, Philadelphia, was recently awarded the Physicians Recognition Award by the American Medical Association.

Thomas K. Oliver, Jr., M.D., has been named chairman of the department of pediatrics at the University of

Pittsburgh School of Medicine and medical director to the Children's Hospital of Pittsburgh. Dr. Oliver was previously director of the pulmonary laboratory at Ohio State University and director of Newborn Service at Ohio State University Hospital.

Harold W. Lischner, M.D., chief of the section of immunology at St. Christopher's Hospital for Children, Philadelphia, was awarded a three year grant which will permit him to continue a study of the role of white blood cells in preventing infection. The grant was provided by the Public Health Service of the Department of Health, Education and Welfare.

John C. Flanagan, Jr., M.D., was recently named medical director of Hahnemann Medical College and Hospital's Outpatient Department. He will direct planning and development of a new type of ambulatory care funded by an OEO grant of \$207,000. The grant will be administered to Hahnemann by the Philadelphia Anti-Poverty Action Committee. Hahnemann will then be able to serve a greater part of the Center City-North Philadelphia population.

Laurence H. Snow, M.D., Philadelphia, has been promoted to professor of psychiatry at the Medical College of Pennsylvania. Dr. Snow will assist Leo Madow, M.D., chairman of the department of psychiatry and neurology in the coordination of various sections of the department.

Smiles speak louder than words for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.

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Menrium® treats
the menopausal
symptoms
that bother him
most.



His wife has a lot of different menopausal symptoms, but only a few really irritate him. Her hot flashes, her vertigo, her palpitations—that's her problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide

5-2

0.2 mg water-soluble esterified estrogens

5 mg chlordiazepoxide

5-4

0.4 mg water-soluble esterified estrogens

10 mg chlordiazepoxide

10-4

0.4 mg water-soluble esterified estrogens

Peer Review For Politicians

Peer review is good for you. This is because it is a fundamentally good idea. It would seem that anyone engaged in an occupation which is highly important to another person or to the mass of our fellow citizens ought to welcome the constructive criticism of his fellow professionals. In striving for methods of practice which offer the most to our patients, we physicians have been learning for many years to make the best use of our resources for patient care.

But there is no reason why an excellent idea like peer review should be limited to the work of the medical profession. My recent amateur observations of the political scene have convinced me that what is now called "the delivery of medical care" is far less in need of peer review than the operations of the men who make our laws at both state and national levels.

It is true that the legislator is subject to the checks of the voters' surveillance of his published activities, but this is not peer review. Moreover, such observations are likely to be sporadic and to cover only small areas of the activities of the legislator.

I repeat: this is not peer review. It also strikes me, possibly in my ignorance, that surveillance by the voting public would be much more effective if balanced by the steady availability of such a critical surveillance by other legislators, by a peer review such as is available to the medical profession, but adapted to our legislative process.

In Pennsylvania we have recently had a good example of the need of some such mechanism. Our state legislators seem to have been less than efficient and less than courageous in passing laws to provide the revenue needed to operate the Commonwealth. In their squirming to avoid the voters' disaffection, they seem to have been something less than statesmen. The "insurance tax" and its almost instantaneous repeal speak for themselves in arguing for a review mechanism by fellow professionals.

On the national scene, the problems are bigger, the bills are higher, the errors are more costly and the oratory more

glamorous, but the expertise does not seem to be greater or more widely distributed among the legislators. Medicare and Medicaid do not give the impression of having been planned by people who looked far into either the past or the future. And if some lateral inspections had been made, Titles XVIII and XIX might have been constructed with better inter-relationships with other laws on the national scene, with some consideration of the work force needed to carry out the plans which the laws represent.

As the *Wall Street Journal* editorialized, "...the government vastly increased the demands on the health industries without anyone having the slightest assurance that the industry could handle the job."

The Health Service Division of the AMA, in analyzing the Senate Finance Committee's Staff Report, points out that administrative costs for Medicare were \$153.5 million in 1968, but only \$110.2 million was budgeted. For fiscal 1969 the government budgeted \$148.8 million for administrative costs but \$193.4 million was needed. The costs of administering Part B exceeded the budget by 48 per cent in 1968 and by 32 per cent in 1969. No peer, I cannot determine if this is justifiable, but it seems that a peer review mechanism would be valuable if it were devised and were available.

Legislators interested in the "delivery of medical care," in "medical manpower" and in the costs of medical and health care are now numerous. Quite properly, and with my applause, they see peer review among physicians as an important mechanism in improving performance in these fields.

It might be to the Nation's good to extend the peer review principle to other fields—to our legislative processes, for example. We might consider the delivery of legislative services, more efficient use of elected manpower, the costs of legislation and the like. Peer review among our elected representatives might lead to striking improvement. A review committee made up of a committee of legislators might, on demand of a sufficient number of citizens, review performance. Things might be improved!

CBL

Environmental Health In Perspective

Give credit to William R. Barclay, M.D., director of the American Medical Association's Division of Scientific Activities (which includes environmental health) for an excellent summary of the importance of environmental health in the context of total health care.

He made the presentation in his capacity as outgoing president of the Tuberculosis Institute of Chicago and Cook County at the institute's 1970 annual meeting. After reviewing the components and causes of environmental degradation, Dr. Barclay laid down this challenge:

"We must educate the public to change its values and expectations. We must help in the drafting of sound legislation. We must promote new codes of social behavior. We must prepare people for sacrifices and for the destruction of an economy based on an ever-increasing gross national product. We must work with others for better housing, better public transportation, limitation of population size and for redistribution of population. In short, the task is to redesign the world. It has taken seventy years to conquer tuberculosis. We don't have seventy years left in which to solve our environmental problems."

Limitation Of Practice

GEORGE A. ROWLAND, M.D.
Millville

Limited medicine is decidedly less than the best. If this is not wholly apparent to doctors, let us, for a moment, consider ourselves as patients or as the parents of patients. In the sick room the trusted family doctor shakes his head. "The cure of your child should be very simple. Unfortunately, Brand X antibiotic has been ordered off the market. Prayer is certainly in order. I always say, 'while there is life there is hope'." Cold comfort.

Patients, in their misinformed way, assume that doctors are free to use the full range of their knowledge and intelligence in picking therapeutic modalities. Of course, sometimes it is the patient himself who limits the physician's option. He may rule out blood transfusions on religious grounds, or hospitalization or surgery because of family or personal bias.

The serious obstacles that should be preventable are my present concern. These are the limitations set by experts, frequently carrying the stamp of the Food and Drug Administration. These words of caution by great minds may sound the death knell of progress in American medicine.

At the turn of the century American medicine was unpredictable, rarely praiseworthy, and largely bad. Physicians used a wide range of methods to fight disease. Most of these, we are informed, were inadequate. Correction of

this chaotic situation was accomplished by the Flexner Commission.

Fifty years later, medical education had been standardized to such an extent that doctors from one end of the country to the other reacted in a highly predictable fashion to almost any medical problem. The standard of medical practice had been raised. At the same time individual initiative had been largely preserved. Each physician had a full range of choice in caring for his patient.

The present trend is carrying Flexnerization to an extreme. It stamps out the crackpot, the Krebiozon devotee, and the basically incompetent doctor. It would also stamp out the Listers, the Pasteurs, and the Semmelweis's who were not in the standard pattern.

Today it is close to sacrilege to criticize peer review, but the dangers in this apparent step forward should be given consideration. When the medical care committee of a hospital analyzes the treatment of coronary disease on the basis of how closely it follows a prescribed regimen. I fear that we are approaching the time when innovative thinking and medical progress will come to a halt. When this sort of limitation is placed upon medical practice we will be at the point where a doctor can be more honored for losing a patient in the prescribed fashion than for saving him by intelligent appraisal of alternatives.

More on Sensitivity Training

A long and fruitful cooperation has existed between the National Education Association and the American Medical Association. This year their Joint Committee on Health Problems in Education has been particularly productive. In one area which has had previous discussion in these pages, they were particularly informative. This subject is Sensitivity Training sessions in schools.

The resolution of the joint committee indicates that such group meetings are becoming more popular. It is clear that one cannot always be sure that they will be conducted by leaders of skill and training. Inadequate leadership may lead to emotional disturbances and personality problems.

The committee's resolution states that individuals should "attend only those meetings conducted by group leaders who have credentials in academic and professional clinical experience." It seems highly likely that the practicing physician can aid in preventing damage from improper use of such group sessions.

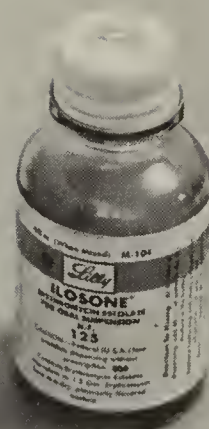
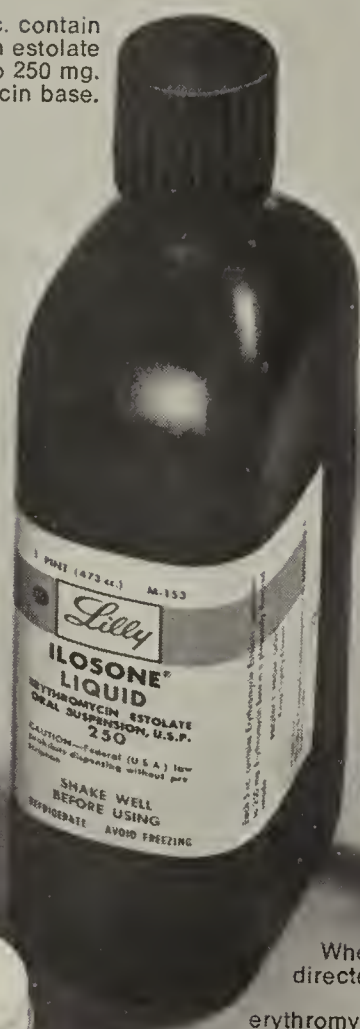
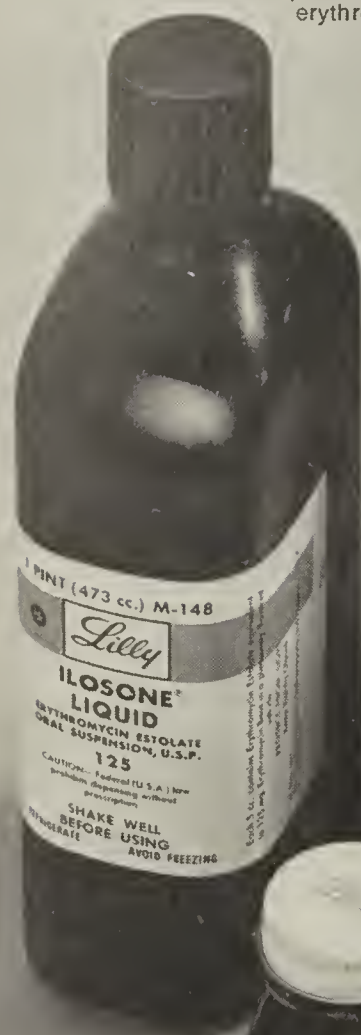
The resolution also points out that: "In some situations individuals are *required* (italics added) to attend such sessions." Physicians can also accomplish much good by taking a stand against improper compulsory use of these sessions.

CBL

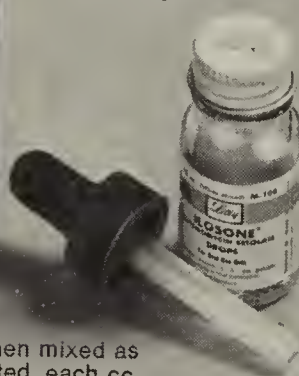


We're running late...he's stuck in his new office chair again.

Each 5 cc. contain
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

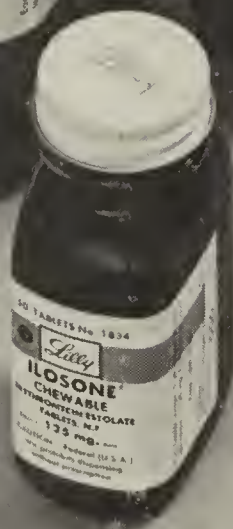


When mixed as directed,
each 5 cc. will contain erythromycin
estolate equivalent to 125 mg.
erythromycin base.

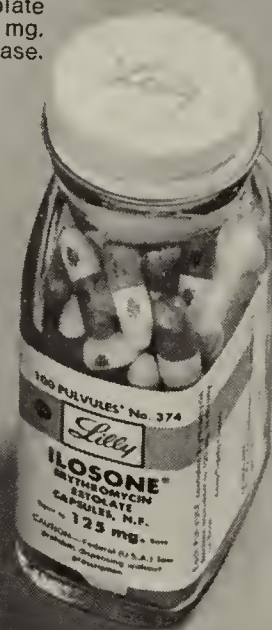
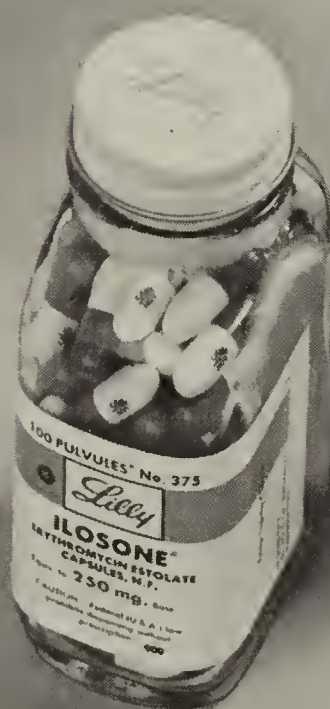


When mixed as
directed, each cc.
will contain
erythromycin estolate
equivalent to 100 mg.
erythromycin base.

Each 5 cc. contain
erythromycin estolate
equivalent to 125 mg.
erythromycin base.



Each tablet contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.



Each Pulvule® contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

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Erythromycin Estolate



Additional information
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Eli Lilly and Company
Indianapolis, Indiana 46206

Each Pulvule contains
erythromycin estolate
equivalent to 250 mg.
erythromycin base.



Screening Of

1,000 Patients

For Inborn

Errors Of

Metabolism

HECTOR TOBON, M.D.
and
JOSEPH S. AMENTA, M.D.
Pittsburgh

Experience In Laboratory Screening At a Children's Hospital

A NUMBER of laboratory screening procedures^{1,2,3,4,5,6,7} have been recommended for evaluating patients with suspected inborn errors of metabolism. To our knowledge there has not been reported in the recent literature either the observed detection rate of such screening programs or the disposition of the cases discovered. The present report attempts to evaluate the effectiveness of such a screening program in use for approximately two years in a children's hospital.

Material and Methods

A morning urine specimen without preservatives is kept refrigerated and warmed to room temperature before the tests are performed. (Cold urines become cloudy upon addition of cetyltrimethyl-ammoniumbromide [CTAB] giving a false positive test.)

The screening procedures test for total reducing substances, glucose, amino acids, some amino acid metabolites and increased acid mucopolysaccharides (AMP). Details of these procedures are now readily available in summary form and are not included in this report.^{1,2,3,4,5,6,7}

All positive tests are checked by a pathologist. After evaluation of the patient and correlation of the history and physical examination with the laboratory data, an initial diagnostic interpretation and recommendations for additional studies are written in the progress notes. In all cases of aminoaciduria and mucopolysacchariduria a twenty-four hour urine is automatically requested for quantitative studies.

Special procedures are usually performed in cases discovered with the simpler screening tests and consist of the following:

1. Single dimensional paper chromatography⁸ in urine or serum for amino acid analysis.
2. Quantification of AMP in a twenty-four hour urine collection by the carbarzole method of Dische.⁹
3. Quantification of amino-nitrogen in a twenty-four hour urine collection.
4. Quantification of amino acids in serum and or urine by column chromatography (this test is usually performed by a commercial laboratory).

At the conclusion of the study, a formal report listing all positive and

negative findings and a final interpretive note is placed on the chart. (Fig. 1)

Results

Reported in this study are the results of screening 1,066 urine samples. Patients submitted for screening were selected by the house staff, usually because of mental retardation or failure to thrive. The present analysis revealed that of 1,066 samples of urine, fifty-eight tests were reported as positive on fifty patients.

During this period there were 17,590 patients admitted to this pediatric hospital. Recognizing that patients in some instances had both multiple admissions and more than a single urinary screen, we would estimate that approximately 6 percent of the children seen in the hospital were initially screened by the house staff and submitted for laboratory evaluation. Of these 1,066 samples approximately 5.5 percent were positive on laboratory screening, giving an estimate yield of approximately 0.32 percent positives for all admissions to referred pediatric hospital.

The fifty-eight positive tests are divided as follows:

- A. Twenty-five positive for increased acid mucopolysaccharides (AMP) by the CTAB Test.
- B. Fourteen positive for increased sulphur containing amino acids by the sodium cyanide-sodium nitroprusside test.
- C. Eleven positive for reducing substances by the Clinitest.
- D. Five positive for ketoacids by the DPNH Test.
- E. Two positive for phenlpyruvic acid by the Phenistix Test.
- F. One positive for glucose by glucostix dip-stick.

All the charts for the fifty positive cases were reviewed and summarized.

A. PATIENTS WITH POSITIVE CTAB

Of the twenty-five positive patients, five were diagnosed as having Hurler's Syndrome¹⁰ (See Table I). In four cases, the diagnosis was fairly obvious from the clinical examination, the laboratory data was merely confirmatory. In one patient (diagnosed as Leg-Perthes disease) the positive screening test was instrumental in suggesting the diagnosis of Hurler's Disease, subsequently confirmed clinically and by the laboratory with a 39.1 AMP/creatinine ratio¹¹ in twenty-four hour

Table 1 Patients with Positive Cethyltrimethylammonium Bromide Test (CTAB) for Mucopolysaccharides.

A. Confirmed with elevated AMP/creatinine ratio in 24 hour urine.

<u>AMP/creat.</u>		<u>Patients</u>	<u>Comments</u>
125 116 185 39.1	1. Hurler's Syndrome	4	3 clinically evident. 1 considered having Leg-Perthes disease on admission; considered as Hurler's variant on discharge
19.99	2. Marfan's Syndrome	1	Associated with congenital megacolon
21.8	3. Microcephaly; mental retardation	1	14 months old, does not sit, no head control, mucus discharge from nose
21.12	4. Hypsarrhythmia, idiopathic	1	Major seizures

B. Normal AMP/creatinine ratio in 24 hour urine.

15	1. Negativism, mental retardation	1	Probable cerebral dysgenesis
13.5	2. Mental retardation	1	Macrocephaly, normal pneumoencephalogram

C. No quantitative test performed.

1. Negative screening in repeated samples	3	Discharge diagnosis: a) Tay-sachs disease, b) Possible cerebral atrophy, c) Congenital nistagmus and delayed mental development
2. Bizarre behavior	3	All mentally retarded
3. Diseases not known to be associated with AMP	3	Discharge diagnosis: a) Convulsive disorder, b) Idiopathic renal glycosuria, c) Cerebral gigantism
4. Probably false positive	6	Convulsive disorders; mental retardation, cause unknown
5. Hurler's Syndrome	1	Clinically evident, 12 years old

urine. One patient with Marfan's Syndrome associated with congenital megacolon demonstrated a mild mucopolysacchariduria with a 19.00 AMP/creatinine ratio. In the patient with microcephaly and mental retardation and in the patient with idiopathic hypsarrhythmia, the positive screening test was confirmed by a 21 AMP/creatinine ratio in both cases, we do not know the significance of this abnormality in these patients. The two patients with normal AMP/creatinine ratios (less than fifteen) are mentally retarded, one has probably cerebral dysgenesis and the other macrocephaly with a normal pneumoencephalogram. In these two patients, the screening test for AMP was considered to be a false positive. In the patients not followed up with quantitative test, three patients had one or two repeat negative CTAB tests. The initial tests in this group were considered false positives. Three patients are mentally retarded and three other patients have diseases not known to us to be associated with increased AMP in urine

(one patient has cerebral gigantism, one a convulsive disorder of unknown etiology and one patient renal glycosuria). The significance of the positive AMP screening test in these six patients is not known. Another six patients were considered diagnostically insignificant positives since relatively high concentrations of mucopolysaccharides are found in urine of patients less than one year of age and none has any evidence of known mucopolysaccharidosis. None of these patients had stigmata of Hurler's Syndrome. Finally, in this group without follow-up quantitative test, is a single twelve year old patient with classical Hurler's, in whom the test was only confirmatory. Of the cases with Hurler's Syndrome recognized on the basis of the clinical and radiologic data, all showed strongly positive CTAB Tests. In fifteen of these twenty-five patients, the Berry Spot Test¹² for mucopolysaccharides was reported as positive or slightly positive. We have discontinued the Berry Spot Test since CTAB Test appeared to be detecting all the cases with elevated urinary mucopolysaccharides.

B. PATIENTS WITH POSITIVE SODIUM CYANIDE-SODIUM NITRO-PRUSSIDE TEST FOR SULPHUR CONTAINING AMINO ACIDS

Of the fourteen patients with urine positive for sulphur containing amino acids (Table II) seven had clinical symptomatology or diagnosis consistent with the presence of sulphur-containing amino acids in the urine. Three of these seven had Fanconi Syndrome. All three had generalized amino aciduria. In most of these cases, the screening procedures confirmed the initial clinical impression. Two patients had cystinosis, both of them with deposits of crystals of cysteine in the bone marrow aspirate. The screening test was diagnostically important in case number three; a ten year old boy with severe mental retardation, frequent seizures and an abnormal EEG suggestive of organic brain disease. Quantitative and qualitative analysis of amino acids in urine revealed amino aciduria with high amounts of cysteine. In case number one, a patient with a renal transplant for hypoplastic kidneys, this positive test was the only evidence of amino

aciduria. No confirmatory tests were performed. We are tentatively attributing this finding to the possible incompetence of the transplanted kidney to handle the filtered amino acid load and at least in this patient, not a finding of any diagnostic significance.

In a second group of seven patients, the findings do not correlate with the clinical diagnosis. However, the patients, cases nine, twelve, and thirteen, were newborn infants and the positive tests could be due to immaturity of the kidneys with associated mild amino aciduria. We have no follow-up on these three patients. In case number eight, a repeated screening test was negative, case number ten was reported as questionable and not repeated; case number eleven was reported as slightly positive and not repeated. Case fourteen is an asthmatic child with mild mental retardation, with a single posi-

tive test. The significance of these tests in these four patients cannot be evaluated.

A typical case of Fanconi Syndrome followed since the age of two days is presented:

CASE REPORT NUMBER 1

This six year, five month old boy was first admitted to Children's Hospital of Pittsburgh at two days of age because of lethargy, cyanosis, apneic spells, and convulsions which started twelve hours after birth. He weighed nine pounds, three ounces and was the first full-term pregnancy of a nineteen year old toxemic mother who had induced labor. A blood glucose of 12 mg/100 ml was found in the baby and he recovered rapidly, after administration of glucose. A glucose tolerance test in the mother was of the pre-diabetic type.

He was seen several times for episodes of hypoglycemia and was treated accordingly. At five years, nine months he was seen for hyperactivity and lack of attention span. He had been toilet trained since two years of age. His I.Q. was sixty, he had good vocabulary, could ride a bicycle, was steady and never clumsy. At this time, the combination of renal glycosuria, growth retardation and clinical evidence of rickets suggested the possibility of Fanconi Syndrome. Screening for in-born errors of metabolism revealed increased sulphur containing amino acids by the sodium cyanide-sodium nitroprusside test; alpha keto acids were detected by the dinitrophenylhydrazine test. One dimensional paper chromatography of the urine revealed generalized amino aciduria, confirmed by quantification of amino acids with column chromatography. He is now functioning in the moderately retarded

Table II Patients with Positive Sodium Cyanide-Sodium Nitroprusside Test for Sulphur Containing Amino Acids

A. Clinical diagnosis consistent with laboratory data.				
Case No.	Sex	Age	Diagnosis	Comments
1	F	13 yrs., 6 mo.	Renal transplant	Hypoplasia of kidneys (Oligomega nephronie).
2	M	8 yrs., 8 mo.	Fanconi with cystinosis	Generalized aminoaciduria on chromatogram.
3	M	10 yrs.,	Cystinosis; mental retardation	Abnormal spot in slow migrating aminoacids.
4	M	7 yrs.,	Familial cystinosis	One sister died with cystinosis at 10 years of age. Cysteine crystals in bone marrow of patient.
5	M	15 yrs., 9 mo.	Chronic renal disease, probably Fanconi Syndrome	Slight aminoaciduria, including cysteine.
6	M	6 yrs., 5 mo.	Fanconi Syndrome	Severe aminoaciduria
7	M	6 yrs., 10mo.	Cystinosis	Cysteine crystals in cornea and bone marrow.
B. Diseases not known to be associated with sulphur-containing aminoacids in urine.				
8	M	11 yrs., 6 mo.	Familial thrombocytopenia; mental retardation	50,000 platelet count; Father and sister with low platelet count.
9	M	17 hrs.	Possible cerebral edema	No follow up.
10	M	5 yrs.	Convulsive disorder	Retarded bone age 3 yr., abnormal EEC. Screening test reported as questionable. No follow up.
11	M	4 yrs.,	Psychomotor retardation	Marked bone age retardation
12	M	96 hrs.	Subarachnoid clot with paraplegia	Respiratory distress; laminectomy; no follow up.
13	M	15 days	Renal glycosuria	GTT in mother normal. Blood glucose 62-94 mg% Reducing substance positive CTAB
14	M	11 yrs.	Asthma; mild mental retardation	Asthmatic since 4 years of age. Poor reading; poor progress in school.

range, rickets is still present with enlargement of the wrists and ankles. He is currently receiving Vitamin D and Schol's solution.

C. PATIENTS WITH POSITIVE CLINITEST FOR REDUCING SUBSTANCES IN THE URINE

These patients have a variety of diagnoses (Table III). Most had glucose in the urine. Cases three, six, and eight were newborns probably with immature kidneys, case two has a Fanconi syndrome and is discussed as case report number one; case four is a seven year old boy with familial cystinosis and positive tests for sulphur containing aminoacids. Two patients, cases nine and ten had only traces of reducing substances. Case eleven is a 4½ year old girl with mild mental retardation. There is no follow-up in this case. Of the remaining two cases, case one is a boy with rubella syndrome, and case seven is an 11½ year old boy with cavernous transformation of the portal vein, portal hypertension without cirrhosis and long history of esophageal bleeding and glucosuria.

It is our impression that this test is not very helpful if no further attempt is made for elucidation of the reducing substance. In some cases the cost will be prohibitive if one considers that some antibiotics, when excreted in urine have reducing properties and are extremely difficult to identify.

D. PATIENTS WITH POSITIVE DINITROPHENYLHYDRAZINE TEST (DPNH)FOR ALPHA KETO ACIDS

This group is composed of five patients (Table IV). Case number one is from our case report one. The second had chronic glomerulonephritis with severe albuminuria; one dimensional paper chromatography was normal and a repeated DPNH test was negative. We believe the initial report is due to a misinterpretation of the test in a turbid urine. The third patient had classical Wilson's Disease with low ceruloplasmin, high copper in plasma, cirrhosis of the liver and splenomegaly at autopsy. Although amino aciduria is well-known in Wilson's Disease, we are not familiar with reports of alpha keto

acids in urine in patients with this disease. Case four was also positive with the Phenistix stick and is discussed in the next section. Case five is our best example of the value of laboratory screening and is presented:

CASE REPORT NUMBER 2

This seven year five month old boy was admitted for the third time for re-evaluation of hepatic and renal function and osteomuscular disorders present for four years. Since 2½ years of age the child developed extreme muscular weakness and inability to walk. During his first hospital admission in 1961 there was muscular wasting in the proximal and distal portions of the lower extremities and a palpable liver, 3 to 4 cm. below the right costal margin. Biopsies of skin and muscle were normal, biopsy of the liver revealed nodular cirrhosis. On his third admission he was well nourished but appeared chronically ill. The liver was nodular, 8.0 cm. below the right costal margin, there was no splenomegaly. The extremities had full range of

Table III Patients with Positive Clinitest for Reducing Substances

Case No.	Sex	Age	Diagnosis	Reducing Substance	Comments
1	M	1 yr., 10 mo.	Rubella Syndrome	1+	Salt and pepper vascular retinal pigmentation. Posterior lens dots consistent with cataracts.
2	M	6 yrs., 5 mo.	Fanconi Syndrome	Positive	Case Report No. 1, Positive DPNH and NaCN See Text.
3	M	16 hrs.	CNS bleeding; bronchopneumonia	2+	4 lb. 9 oz., respiratory distress precipitous delivery; died.
4	M	7 yrs.	Familial cystinosis	1+	Positive for S containing aminoacids. See text.
5	F	3 months	Renal glucosuria	4+	1280 mg. of glucose in 330 cc. of urine.
6	F	5 days	Transient tubular dysfunction Etiology unknown	1+	Glucose present in urine; no acetone. Normal on physical examination.
7	M	11 yrs., 6 mo.	Cavernous transformation of portal vein	4+	Portal hypertension without cirrhosis; long history of esophagea bleeding, glucosuria.
8	M	15 days	Renal glucosuria	4+	Normal GTT in mother. Blood glucose 67-94 mg%. CTAB and NaCN positive. Normal chromatogram.
9	M	3 yrs.	Mental and physical retardation	Trace	Runny nose and discharge from ears. Followed in development clinic for hearing impairment.
10	M	4 yrs.	Psychomotor retardation	Trace	Slightly positive NaCN. Cerebral dysrhythmia on EEG.
11	F	4 yrs., 6 mo.	Mild mental retardation	Positive	Sister 9 years old, retarded. No Follow up.

Table IV Patients with Positive Dinitrophenyl-Hydrazine Test (DPNH) for Alpha Keto Acids

Case No.	Sex	Age	Diagnosis	Comments
1	M	6 yrs., 5 mo.	Fanconi Syndrome	Case Report Number 1. See Text.
2	M	14 yrs., 8 mo.	Chronic glomerulo-nephritis	Normal paper chromatography for aminoacid in urine. Repeat screening negative.
3	M	11 yrs., 6 mo.	Wilson's Disease	Ceruloplasmin 11.3 mg%. Plasma Copper 108 mcg.%. Cirrhosis, splenomegaly at autopsy. Phenistix positive.
4	M	15 months	PKU	Case Report Number 3. See Text group E.
5	M	7 yrs., 5 mo.	Tyrosinosis	Case Report Number 2. See Text group D.

motion and exhibited decreased muscular mass. Screening for inborn errors of metabolism were positive for alpha keto acids. One dimensional paper chromatography of urine revealed amino-aciduria with an abnormal spot identified as tyrosine. Tyrosine in blood was 15.8 mg percent. Quantitative determination of amino acids in urine by column chromatography revealed 2500 micromoles of tyrosine in a twenty-four hour urine sample. Quantitative analysis of phenylacetic acids in urine showed at least ten-fold increase. This data confirmed the diagnosis of tyrosinosis.

The patient was started on a low tyrosine, low phenylalanine diet (Mead-Johnson). His strength and general energy level have increased. He has gained weight and his only medical problems have been mild upper respiratory infections and bilateral otitis media which have responded to antibiotic therapy.

E. CASES POSITIVE WITH PHENISTIX FOR PHENYLPYRUVIC ACID

Of the two patients positive with phenistix, one is the patient with Wilson's Disease presented in the preceding section. The other patient is a fifteen month old boy admitted for evaluation of mental retardation and seizures of nine months duration.

CASE REPORT NUMBER 3

He was the product of a normal gestation, labor and delivery and weighed seven pounds, four ounces. He sat at one year and never walked. The physical examination revealed a white retarded child in no distress. The vital signs were normal and the rest of the physical examination revealed only poor balance of the head

and trunk. The child did not talk. The screening for metabolic disorders were positive for keto acids in the urine. A chromatogram of the urine showed an abnormal spot at the phenylalanine position. Phenylalanine determination in serum was 33 mg percent. The patient was discharged with a phenylalaine level of 12 mg percent and a tyrosine level of 1.12 mg percent. He is on a low phenylalaine diet, is active, walking and beginning toilet training. He is trying to talk and recovering some of his motor control.

Discussion

Of the 17,590 patients admitted to the hospital during a two year period, 1,066 samples were submitted for IEM screening. Of these fifty-eight were positive (5.4 percent) in fifty patients, a 5 percent yield in 1000 selected patients. This is a rather low yield for a population originally selected by personnel acquainted with metabolic diseases and problems of mental retardation. The yield, however, cannot be counted in numbers only. The screen-

Fig. 1: CLINICAL CHEMISTRY SCREENING FOR INBORN ERRORS OF METABOLISM

Name	Unit No.	Location
Date		
1. Glucose		
2. Reducing Substances		
3. Phenistix		
4. DPNH Test		
5. CTAB Test		
6. Sodium Cyanide-Sodium Nitroprusside Test		
7. Nitrosonaphthol Test		
8. Ninhydrin Test		
9. Aminoacids by Paper Chromatography		
Remarks:		

CC Form 2: 11/67

The screening and

. . . tests have been most

helpful in

confirming clinical

diagnoses . . .'

ing and quantitative tests have been most helpful in confirming clinical diagnoses, e.g. Hurler's, Marfan's and Fanconi's Syndromes, which of course, is one of the classical functions of the laboratory. In addition these procedures have provided diagnoses in unexplained cases, such as the patients with thyrosinosis, phenylketonuria and Leg-Perthes diseases. Under these specific conditions at least, a valid argument can be made for IEM screening. The value of screening all patients in the pediatric age group remains as yet undefined.

From the rather low yield (5.4 percent) from selected patients by selected

staff, we doubt very much that this program may be of value in mass screening. No matter how good the screening procedure is, we still prefer one alert pediatrician to the impression that "all" metabolic problems have been ruled out by the laboratory.

Technical Considerations and Cost

The total direct cost for the routine screening procedure is \$2.86, for the laboratory. We are now performing approximately sixty screening procedures per month at a cost to the patient of \$7.00 per screening procedure. The screening is easy to perform, requires little equipment and most of the reagents are stable. Several specimens can be run at one time with the data available within an hour. In addition, expensive quantification of amino acid may be avoided, if the screening procedures are used first.

Limitations

Essential to the successful operation of an IEM screening program is the interest and direct participation of at least one physician. A positive screening test is almost valueless, without additional tests since no test by itself is specific or diagnostic. The role of the laboratory physician is defined by his correlation of clinical and laboratory data and his recommendations for further studies. In our experience, without some guidance from a laboratory physician unusual laboratory results tend to be regarded as laboratory errors if they do not fit preconceived ideas in a given patient or disease. Part of the armamentarium of the ready availability of the more sophisticated laboratory test is essential for definitive diagnosis. If this is not possible within the screening laboratory close relationships with a reference laboratory and additional consultation is advisable.

Drs. Tobon and Amenta are associated with the department of pathology at the University of Pittsburgh School of Medicine. Presently Dr. Tobon is assistant professor of pathology. Dr. Amenta is on sabbatical leave. The paper was presented before the American Society of Clinical Pathologists.

Summary

A group of screening tests designed to detect inborn errors of metabolism were performed on 1,066 urines selected from total hospital admissions of 17,590 children. A total of fifty-eight tests (5.4 percent) in fifty patients (5 percent) were found positive in this preselected population.

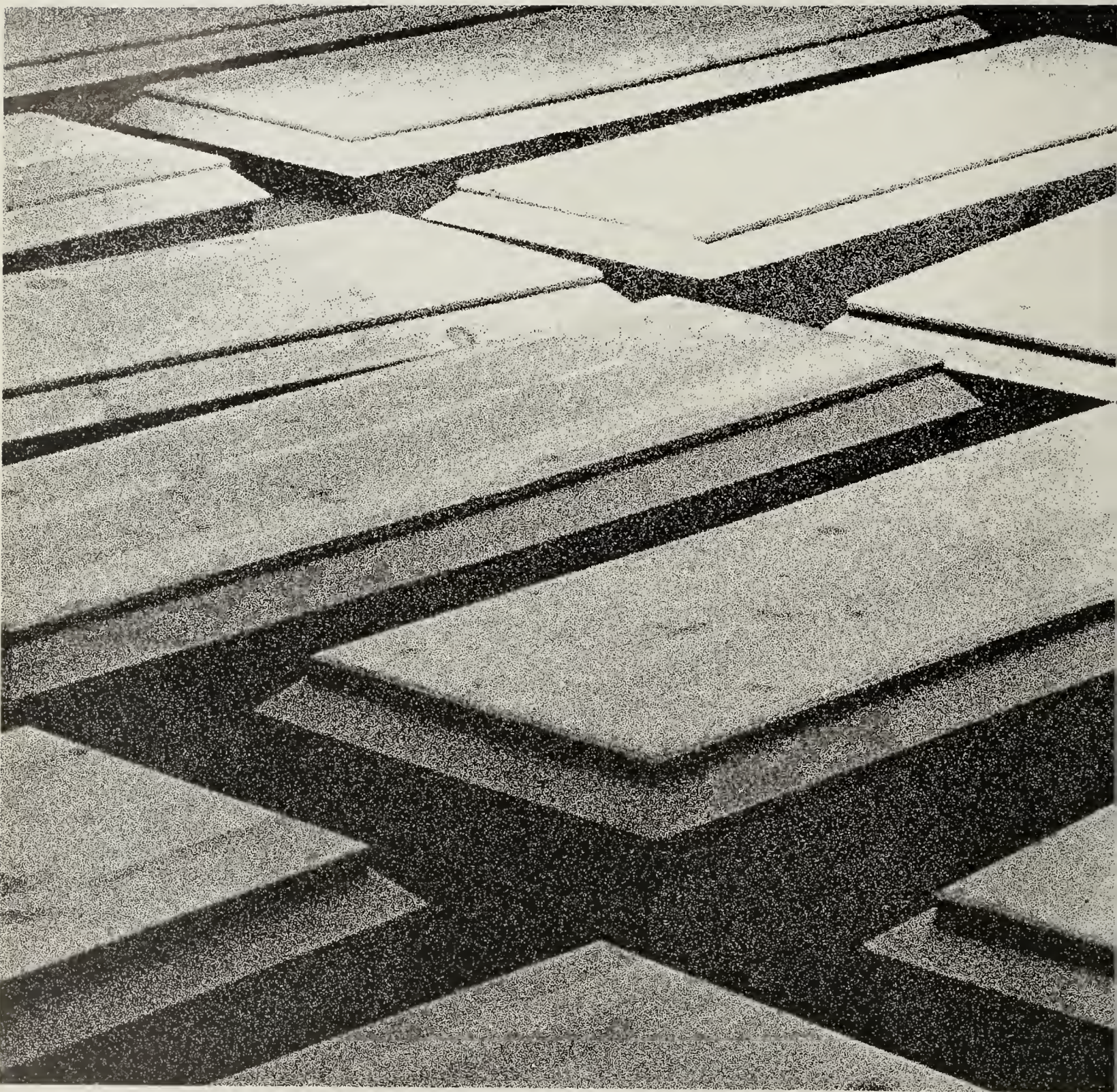
With this approach of clinical pre-screening by the pediatric staff and clinical screening by the laboratory, a total yield of 0.32 percent positives for the 17,590 admissions was found. The diagnostic and therapeutic value of these results are presented.

We are indebted to the entire staff of the Clinical Chemistry Laboratories of the University of Pittsburgh for their cooperation and encouragement.

□

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Hiroshima 1945? No, Pennsylvania, 1980.

No sirens crying a warning.
No wrenching thunder of bombs hurtling down.
Just a new kind of death on a mass scale.

By 1980, the simple act of breathing our polluted air may cause death on a scale never before imagined. Silent, creeping, ugly death, killing more people quicker than were killed in all the wars in the entire history of mankind.

Who can say at just what point your lungs can't take any more? How much poison can we keep spitting in the air before it comes

Courtesy of the Philadelphia Gas Works.

Before it does something to you.

Don't think for a minute that new laws are the answer. Unless you see to it that any law is enforced, it will be useless. A law that is not enforced is worse than no law at all. Because it deludes us into thinking that the problem is solved when it's anything but solved.

So fight back and look out.
back to kill us?

By the time we find out, it may be too late.
Do something about air pollution now.

A Viable Organ Bank

THE PROBLEMS of transplantation of organs can be divided into three divisions; technical, immunological and logistical. The technical aspects include the surgical and physiological procedures necessary for transplantation which, except for components of the central nervous system, have been nearly solved. The immunological problems have been partially solved. Until recently the problem of logistics have more or less been ignored but may prove to be the limiting factor in organ transplantation. Logistics involve the legal and moral issues in obtaining the organs needed as well as the process of maintaining the organs in an undamaged condition until used.

A bank of human tissue for clinical use was established at the Harrison Department of Surgical Research at the University of Pennsylvania in 1953.^{1,2} Freeze dried tissue such as blood vessels, fascia and skin was supplied until 1958 when the emphasis shifted to the development of a viable organ bank for long term or semi-permanent preservation.

Methods of storage and the capacity to move the stored tissue from a central bank to various hospitals for the clinical use have been developed. Since attempts to freeze-dry tissue retaining its viability failed,³ freezing and storage in liquid nitrogen was investigated. Mammalian cells grown in tissue culture, rat skin, canine parathyroids, small bowel, lung, heart, stomach, blood vessels and kidneys, as well as rabbit hearts and kidneys, all have been used in experiments studying the preservation of tissue viability after frozen storage.^{4,5,6,7,8,9,10} A clinical bank was established for the long term storage of viable frozen skin, using this skin to treat patients with burns and chronic ulcers.¹¹

The technique of preservation varies from tissue to organ but the principles

are the same. The viable tissue is perfused with or incubated in a protective agent, either glycerol or dimethylsulfoxide. After controlled slow freezing, the skin is stored in liquid nitrogen (-195°C). Reimplantation of this skin as an auto or allograft follows controlled thawing. These procedures have resulted in questions that have been only partially answered i.e. (1) the cause of injury or death of tissue by freezing; (2) the action of protective (cryoprotective) agents; (3) the effects of the rates of freezing, storage temperature and thawing on the tissue or organ to be stored; (4) the cumulative effect of these processes on the subsequent viability of the graft; and (5) the possible effects of these processes on the immune reaction if this tissue is used as a permanent allograft.

Mammalian cells grown in tissue culture have been the model used to achieve data applied to experiments using rat skin and to more complex organs like small bowel and/or kidney. Standard tissue culture techniques for mammalian cells showed that to retain maximum viability the cryoprotective agent (glycerol or dimethylsulfoxide) should be between 5 - 10 per cent by volume.^{12,13} Insulin and corticosteroids in the prefreeze culture media have enhanced the viability after freezing but did not produce a cumulative effect. Rapid thawing in the range of 40 to 60°C per minute yielded better survival than slow thawing but most of the cellular damage appeared to occur at the phase change from ice to water,¹⁴ at which time it is difficult to measure intracellular events.

To test these data, grafting was performed in rats by switching skin from the back to the abdomen. The grafts were measured at application and again at one month. The difference in graft size was subjected to statistical analysis. Four variables^{16,17,18} were found to significantly affect the viability of the rat skin grafts as measured by the amount of the contraction in the frozen grafts compared with unfrozen grafts. These variables were the time of contact of the skin with the

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protective agent prior to freezing, the temperature of the protective agent, the concentration of the protective agent (glycerol or dimethylsulfoxide) and the rate of thawing. The rate of freezing and differences between glycerol and dimethylsulfoxide as protective agents did not have any significant result on the amount of shrinkage of the graft. The maximum protective effect for rat skin was obtained using 10 per cent by volume of glycerol or dimethylsulfoxide. Increasing percentages of these agents did not decrease the amount of contracture of the grafts. In other organs, it has become apparent that if the ratio of the surface area to the volume of the organ was small, e.g. kidney, thawing by conduction was unsatisfactory. When a kidney was thawed by con-

ducted to measure the effect of the variables of the duration of contact of the cryoprotective agents with the organ, the concentration of the cryoprotective agents, and the rate of thawing.

Skin

The data obtained from the experiments with rat skin were used to establish a bank for human skin in 1964.¹¹ The human skin used for storage was taken under sterile conditions either from a patient or from a fresh cadaver. Originally the skin was soaked in a 10 per cent solution of dimethylsulfoxide or glycerol in a 0.9 per cent saline for approximately fifteen to thirty minutes and then cut into pieces which would comfortably fit into a finger cut from a sterile rubber glove. The skin was placed in the rubber ampule which was ligated, wrapped in a paper towel, and placed in a dry ice chest at -79°C for approximately twenty-four hours. This gave a rate of freezing of approximately 1°C . per minute. For permanent storage this packet was placed in a liquid nitrogen refrigerator in which the temperature was -196°C . in the liquid phase and approximately -180°C . in the vapor phase. Theoretically, the storage temperature should be below -130°C . which is the temperature at which the last physical change of ice occurs. When the skin was to be used as a graft, it was transported in a vacuum bottle filled with dry ice (-79°C .), and thawed by agitation in a water bath at 37°C . This achieved a rate of thawing between 50 and 70°C . per minute. The skin was then used as a fresh graft on the patient's wound.

Further experiments with rat skin indicated that the soaking time in the cryoprotective agent of fifteen to thirty minutes was not sufficient and that from two to four hours gave better results.¹⁶ Cultures of human skin prepared by these techniques were found to grow epithelial cells poorly. Epithelial cell growth was much better if 20 per cent glycerol or dimethylsulfoxide was used as the soaking agent.¹⁹ The fibroblasts grew well at both 10 per cent and 20 per cent concentrations. At the present time, it is recommended that human skin for storage be incubated in 20 per cent glycerol or dimethylsulfoxide by volume in 0.9 per cent saline for at least two hours during which the temperature of the solution is allowed to fall from ambient temperature to 4°C . in a refrigerator before being frozen. The

other steps of procedure would remain the same.

The skin has been used as autografts and allografts. The allografts appear to be more useful than autografts, but in a patient requiring multiple autografts, it is possible to harvest enough skin at the first grafting procedure for all grafting needs, freeze the excess, and then use this frozen skin as needed later. This technique may reduce the need for anesthesia and allow grafting procedures to be done outside of the operating room.

As allografts, this skin has been used for biologic dressings and to cover large areas of granulating tissue when insufficient autograft is available. Second degree burns, traumatic and stasis ulcers, fresh avulsion injuries and even split thickness skin graft donor sites have been treated with stored viable allograft skin.^{20,21} When used as a biologic dressing, the skin is usually not allowed to develop a firm vascular bond, but it is lifted from the wound bed approximately every seventy-two hours until the graft becomes necrotic or replaced with new allografts every three to five days. Preparation of a wound for autografting may be facilitated by this technique. In some wounds, marginal epithelization has proceeded at such a rapid rate autografting has not been necessary. When these allografts begin to develop a vascular bond, there is a good indication that the donor site is ready for an autograft.

Objective data of the usefulness of these allografts is difficult to obtain under clinical conditions. In several patients with two ulcers of approximately the same etiology and duration, the ulcers have been treated similarly except one was covered with an allograft; the rate of epithelization of this ulcer was significantly more rapid than the ulcer treated without the allograft.

In patients with massive burns this skin has been used to provide coverage by allowing the skin to heal and then be rejected and this process continued until grafts of the patients' own skin are available for coverage. These results are comparable to those reported by other investigators.²²⁻²⁶

Approximately 150 patients have received allografts from the bank. The major problem now is keeping sufficient skin in the bank to meet the demand. Most of the skin is obtained by asking the families of patients who have died for permission to take skin

*'The problem now is
keeping sufficient skin
in the bank to meet
the demand.'*

duction alone, the rate would be slow, and would be in the range of thawing rates which gave poor recoveries of viable cells grown in tissue culture and poor results with rat skin. The organs studied were classified into two groups based on the surface to volume ratio. The organs with a large surface to volume ratio are skin, small bowel, stomach and parathyroid glands. The organs with a small surface to volume ratio are kidney and heart. Most methods used to thaw the solid organs rapidly throughout require the use of electrical energy.

A series of experiments utilizing parathyroid glands, small bowel, stomach, kidney, heart and lung were

from unexposed areas. The grafts are then removed in the operating room with a dermatome set at medium thickness (.012-.014). However, bits of unused skin from skin grafting procedures are stored and skin from extremities amputated for non-malignant or non-infectious disease has been banked.

Kidney

Experiments for the long term preservation of the kidney were done using canine kidneys. One kidney was removed by laparotomy and after treatment, was reimplanted in the dog's neck by anastomoses to the carotid and jugular vessels or in the inguinal area to the femoral vessels with the ureter brought out as a cutaneous ureterostomy. The kidneys have been perfused with balanced salt pH adjusted solutions containing 5, 10, or 15 per cent dimethylsulfoxide by volume. The perfused kidneys have been cooled to -6°C . and rewarmed and reimplanted as autografts.

None of these perfusates except the one containing 15 per cent glycerol by volume has had a permanent deleterious effect on the kidney.

However, when the kidneys have been frozen and thawed the results have been unsatisfactory; none of these kidneys have functioned sufficiently to sustain the life of the animal. To thaw a 60 gram canine kidney by conduction heating alone takes nine to ten minutes which is too long. Three methods of electrical heating have been investigated: dielectrical heating, microwave heating, and sixty cycle conduction heating. All of these methods present difficulties in controlling the amount of electrical energy so that it is distributed evenly and so none of the areas of the kidney are over heated. Different tissues have different electrical capacities; and the

electrical characteristics of tissue change with temperature. The electrical conductivity of the kidney increases with temperature over a wide range of frequencies. Because of this, heat produced by the electricity will tend to concentrate so that a warm area will get warmer while a frozen area will be unaffected. This has been termed "thermal runaway." Kidneys are transparent to magnetic energy so induction heating cannot be used. Also it is possible not to place metallic thermocouples within the kidney substance during the thawing process because they instigate "thermal runaway."

Using a microwave (radar) oven with a technique to prevent overheating, it is possible to thaw a 60 gram canine kidney at an acceptable overall rate, but none of these kidneys have survived. This may be because areas of the organ are overheated since the measurements of temperature cannot be made while the organ is being treated.

A viable kidney with normal pelvis, ureter, and glomeruli has been obtained by dielectric heating (diathermy); however, the tubule cells have been too damaged to function. This method of thawing has disadvantages and is not considered as promising as the other two methods, particularly when larger organs are to be thawed.

A method of thawing the kidney has been developed using sixty cycle house current passed through the kidney tissue. It may become possible to thaw a kidney in a more controlled fashion by this method.

Small Intestine

Canine small intestinal segments 10 cm. in length were perfused through the arteries with 10 per cent dimethylsulfoxide oxidated plasma-balanced electrolyte-dextran solution for thirty minutes; frozen at the rate of $3^{\circ}\text{--}4^{\circ}\text{C}$. per minute to -50°C . or colder and thawed at 50°C . per minute. The bowel was then reimplanted in continuity or placed as a graft in the neck of the animal and anastomosed to the jugular vein and carotid artery with the intestinal lumen brought out as a mucous fistula. Segments have survived this technique with apparent mucosal regeneration and the return of peristalsis and function. In one animal, whose segment was replaced in continuity in the gastrointestinal tract, laparotomy was performed at two months and again at two years post operatively. The segment appeared to be grossly

normal. At two years, peristaltic waves passed through this segment and dilute glucose solution was absorbed from the lumen against a concentration gradient. Biopsies were histologically normal. Mucosal tissue was tested in vitro for active transport of glucose and amino acids. Compared to the adjacent unfrozen mucosal biopsies, rates of active transport were: alpha-methylglucoside glucose transport 10.7 per cent, valine 48 per cent, lysine 55 per cent. Extracellular fluid space (C^{14} inulin measurement) in the frozen-preserved mucosal biopsies was increased, 24 per cent versus 17 per cent in the control segment, suggesting a mild chronic edema of the frozen preserved segment. It appears as though this frozen preserved organ suffered no significant functional deterioration two years after implantation.

Experimental techniques are being enlarged now to freeze enough of the small bowel so that the animal can live entirely with frozen small bowel.

Parathyroid Glands

Hormone producing cells grown in tissue culture retain their hormonal producing capacities after freezing and thawing.²⁷ The canine parathyroid was chosen as a whole test organ because it was small enough to freeze and thaw rapidly.

The parathyroid glands were soaked in 10 per cent glycerol by volume in a balanced salt solution, frozen to -79°C . for one hour; thawed rapidly at 37°C . by conduction and implanted in the substance of the strap muscles of the dogs as autografts. An experimental canine model with an 80 per cent mortality has previously been developed in our laboratory.²⁸ Sixty-six mongrel dogs were used in this experiment. Dogs received either one fresh or frozen autograft or multiple fresh or frozen autografts. Dogs receiving one autograft fared little better than those with simple excision. This mortality rate was 75 per cent. Dogs receiving multiple fresh or frozen implants had an overall mortality of 30 per cent. Fresh autografts were slightly superior to frozen autografts with regard to insuring survival.

Stomach

The stomach has the physical characteristics of small bowel and can be frozen and thawed by the same techniques as those developed for small bowel. All elements have survived but preliminary results indicate that the

This study was supported by a grant from the John A. Hartford Foundation for Surgical Research to the Harrison Department of Surgical Research, University of Pennsylvania School of Medicine. Dr. Lehr is associate professor of plastic surgery at the University of Pennsylvania School of Medicine; Dr. Hamilton and Dr. Graham are assistant professors of plastic surgery there and Dr. Holst is a plastic surgeon at Lankenau Hospital. Dr. Berggren is associate professor in plastic surgery at Ohio State University School of Medicine, Columbus, O.

*To date, no
frozen-thawed
hearts or lungs
have been
successfully
reimplanted.'*

parietal cells are more affected than others of the elements of the stomach.

Heart and Lungs

The studies with these organs are very preliminary. It has been possible to keep a heart alive for forty-eight hours outside of the body, but this has been in a Carrell-Lindbergh apparatus with hypothermia. To date, no frozen-thawed hearts or lungs have been successfully reimplanted. These experiments are still in the preliminary stages.

Summary

The problems of long term storage of organs for clinical use have been outlined. A clinical bank for viable skin has been established, which has no advantage over earlier skin banks, particularly that described by Webster,²⁹ except for the advantage of indefinite storage. Experiments on other organs in animals are encouraging, and human adaptation seems within reach in the near future. □

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Pneumoperitoneum Associated With Jejunal Diverticulosis

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Fig. 1: Chest X-Ray Demonstrating Pneumoperitoneum.

DIVERTICULOSIS of the jejunum is a relatively unusual finding and the cause of significant symptoms in less than 50 per cent of patients in whom diverticula are found. The most frequent symptoms are a result of low grade intestinal obstruction. These consist of flatulence, upper abdominal discomfort, a feeling of abdominal fullness and vomiting after meals. Other less common complications are acute obstruction, inflammation, bleeding, perforation, inspissation with enterolith formation, and macrocytic anemia with impaired intestinal absorption progressing to combined degeneration of the spinal cord. The most uncommon clinical finding in jejunal diverticulosis is pneumoperitoneum occurring spontaneously and unassociated with signs or symptoms of peritoneal irritation. Altemeier¹ reported this complication in one instance. Nansom and Dragon² have reported one case and Herrington³ has reported one case.

This communication documents another case of spontaneous asymptomatic pneumoperitoneum in a sixty-eight year old woman with diverticula of the jejunum, which were also the cause of low grade intestinal obstruction.

Case Report

A sixty-eight year old woman (C.D.) was admitted to Sacred Heart Hospital on May 4, 1969 with a chief complaint of abdominal discomfort and intermittent vomiting of seven years duration. Diverticulosis of the duodenum, jejunum and colon had been demonstrated by barium study of her intestinal tract seven years previously. On May 5, 1969 sigmoidoscopic examination was performed. The sigmoidoscope was passed 22 cm without difficulty and with no unusual discomfort. A routine chest x-ray taken one half hour later demonstrated free intraperitoneal air beneath the right hemidiaphragm (Fig. 1). The patient was completely asymptomatic. No abdominal pain or tenderness was present. The vital signs were within normal range, and there was no leukocytosis. She was treated by observation only and remained symptom free. An x-ray taken on May 8, 1969 showed that the free air had almost completely resorbed. The patient was discharged from the hospital on May 10, 1969.

On June 8, 1969 she was readmitted

to the hospital. During the interval since discharge, she had continued to vomit intermittently and noted upper abdominal pain. A barium enema demonstrated many small colonic diverticula. Multiple air fluid levels, the results of retention in jejunal diverticula were seen in the left upper abdomen. X-ray of the upper gastrointestinal tract showed a single duodenal diver-



Fig. 2: Barium study of upper gastrointestinal tract showing two jejunal and one duodenal diverticula.

ticulum, multiple jejunal diverticula, (Fig. 2) and a possible duodenal ulcer.

Medical treatment was elected, placing the patient on an ulcer regimen, but she continued to have abdominal pain and repeated vomiting.

On June 30, 1969 a vagotomy, pyloroplasty and resection of a 90 cm length of jejunum was performed. The pathologist reported that the largest diverticulum measured 6 cm in diameter, and that sections revealed the walls of the diverticula to be extremely thin at several points.

Her recovery from surgery was uneventful except for the development of a wound abscess which responded to simple drainage but prolonged her hospital stay. She was discharged from the hospital on July 24, 1969.

When last examined in September 1969, the patient felt well and was free of the intermittent vomiting and abdominal discomfort which had been present for the previous seven years.

Comments

Free air may be found within the peritoneal cavity after rupture of an intra-abdominal hollow viscus and has

This . . . documents another case of spontaneous asymptomatic pneumoperitoneum in a woman with diverticula of the jejunum.'

also been noted after distention of the stomach or colon during gastroscopic or sigmoidoscopic examination. Air may be introduced into the peritoneal cavity during abdominal surgery or for diagnostic or therapeutic purposes. Spontaneous pneumoperitoneum has been noted in pneumatosis cystoides intestinalis, and there have been reports of idiopathic pneumoperitoneum in which at laparotomy no cause for free air has been found.

In the case being reported, sigmoidoscopic examination was performed immediately prior to the discovery of pneumoperitoneum. This examination, however, was uneventful, and it seems extremely unlikely that leakage of air occurred during this procedure since the patient experienced no discomfort at that time and the colon was not distended with air.

The mechanism by which gas escapes from jejunal diverticula has not been

fully explained. Herrington suggests that intestinal gas passes through microscopic perforations in the thin walls of the diverticula during hyperperistalsis. Altmeier reported seeing the formation of subserosal blebs during periods of intense hyperperistalsis while observing jejunal diverticula at the time of laparotomy. Nansom and Dragon postulate the presence of openings so small that gas passes through the diverticular wall while fluid remains within the bowel lumen. Bacteria which may accompany the gas are thought to be dealt with by the peritoneal defense mechanism.

In reviewing the three previously reported cases it is noted that all patients also had symptoms of low grade obstruction and it seems reasonable to postulate that increased intraluminal pressure of a chronic nature is the common denominator for spontaneous gas leakage through the thin walled diverticula.

Summary

Although jejunal diverticula are not usually symptomatic, they may give rise to a variety of clinical manifestations and complications.

These complications are briefly discussed, and a case is presented in detail in which pneumoperitoneum without signs of peritoneal irritation occurred in association with jejunal diverticulosis. The method by which gas escapes into the peritoneal cavity is considered. □

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2. Nansom, E. M., and Dragon, G. E. A spontaneous pneumoperitoneum due to jejunal diverticulosis.
3. Herrington, J. L. Jr. *Am. Journ. Surg.*, 113, 567-510 1967. Spontaneous asymptomatic pneumoperitoneum.



Dr. Armitage is in the practice of general surgery in Chester, and currently is serving as chief of surgery at Sacred Heart Hospital there. He is a graduate of Jefferson Medical College.

Correlation Of Retinal Vascular Changes With Cardiovascular Diseases

Part I Arteriosclerosis

Thomas B. Souders, M.D., ophthalmologist, Reading Hospital, West Reading, is questioned by William G. Leaman, Jr., M.D.

Will you describe the uniqueness of the retinal circulation in the cardiovascular diagnostic study?

The retinal circulation is the only portion of the circulatory system to be directly visible, and thus it represents a unique field of study in cardiovascular disease. However, it is only incompletely representative of the vascular system as a whole since not all vascular diseases can be found here. Nevertheless, those which affect the retina manifest themselves in ways which can be helpful to the diagnostician. The retinal arterial system is comprised primarily of arterioles, smaller arteries which have shed their elastic lamina and contain a muscular coat which is not continuous. Only the central retinal artery and its first branches in the immediate vicinity of the optic disc contain elastic lamina and are true arteries. Therefore, the retinal system does not participate in certain of the disorders affecting the major vessels of the body. In the vascular system of the retina, arteries and veins are bound at their points of crossing within common adventitial sheaths, a phenomenon found in no other organ. Thus bound together, the two vessels are intimately affected by various pathologic conditions. For example, atheromatous plaque formation may begin in the artery and progress into the vein and cause venous occlusion. The A-V crossings undergo changes in arteriolar sclerosis which can indicate the progression and stage of pathologic involvement of that disorder. One further point of singularity of the

retinal vascular system is that it receives external support from and can be affected by the intraocular pressure. In glaucoma, a state of abnormally high intraocular pressure, development of signs of hypertension are retarded, but the risk of venous occlusion is increased.

What are the changes of greatest importance in assessing arteriosclerotic involvement of the retina?

The significant pathologic changes include broadening of the arteriolar light reflex, changes at the A-V junction, narrowing of the arterioles, and focal plaques within the vessel walls. In addition, severe cardiovascular disease may cause a failure to maintain an adequate retinal circulation and induce dramatic secondary signs. These include hemorrhages, "hard" exudates, "cotton wool" spots, aneurysms, retinal edema and detachment, and papilledema.

Which cardiovascular disorders cause changes in the retinal vessels?

Intimal atherosclerosis, involutionary sclerosis and arteriolar sclerosis all manifest themselves in the ocular circulation. Several disorders never occur there. These include senile ectasia, and Monckeberg's sclerosis, both diseases of the major arteries.

How does intimal atherosclerosis show in the retinal circulation?

Atherosclerosis is the most common arterial disease to affect man, and is characterized by the deposition of lipid material within and beneath the retina associated with hyperplasia and degenerative changes in the arterial wall. Found in the great vessels, the

coronary and cerebral circulations, it predisposes to aneurysm formation and thrombosis, and thus to sudden vascular accidents. The ocular circulation is not immune to these, suffering central retinal artery or vein occlusions from thrombotic plaques within the vessels. Ophthalmoscopy may reveal distinct, focal grayish-white plaques in the arteries near the disc with no apparent disturbance in retinal circulation until an occlusive catastrophe occurs. The process of atherosclerosis is capricious, involving as it does the arteries of the body in random fashion. Therefore, correlation cannot be made between retinal atherosclerotic plaquing and the existence of similar plaques in the coronary arteries or elsewhere in all cases.

What is involutional sclerosis?

With the aging process, changes occur in the vessels which involve fibrous and hyaline degeneration of their muscular coats. The retinal vessels suffer this damage from the wear and tear of time, and such change is more or less universal with the fifth or sixth decade. The arterioles become paler and their central reflected light streak duller and broader as the muscular coat is replaced by fibrous tissue. The vessels may appear slightly reduced in calibre, or attenuated, straighter than normal with a more acute angle-branching at their points of bifurcation. Such changes mimic those of early, benign hypertension, but, of themselves, are not considered pathologic in the absence of elevated blood pressure.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

The Diagnosis Of Leukemia

WHAT IS LEUKEMIA?

Leukemia may be considered a malignant dysfunction of the bone marrow in which the abnormally proliferating cells crowd out the normal blood cell lines. As a result, anemia, bleeding and infection are the chief manifestations of the uncontrolled disease.

WHAT IS THE CAUSE OF LEUKEMIA?

The cause is still speculative, of course. Most likely there are multiple etiologic agents. Viruses have been proved to cause leukoses and other leukemia-like diseases in non-human species and are prime suspects in the human leukemias. Environmental factors such as irradiation, chemical agents such as the benzene derivatives and genetic influences are also considered.

WHAT TYPES OF LEUKEMIAS ARE THERE?

The leukemias of most clinical importance fall into five main types: acute and chronic granulocytic, acute and chronic lymphocytic and myelomonocytic leukemias.

WHAT ARE THE CLINICAL SIGNS OF LEUKEMIA?

These are protean and non-specific. Onset may be abrupt with fever, prostration, pallor, subcutaneous hemorrhage and lymphadenopathy. This acute type is the one often seen in children. In the older group the onset is usually insidious and sometimes lymphadenopathy and/or splenomegaly are the first signs of trouble. Arthritic symptoms may also appear as a presenting sign.

HOW IS THE DIAGNOSIS MADE?

Most leukemias are picked up by



routine blood studies. A well-stained blood smear is the best screening tool. Suspicious smears should be followed by complete red and white blood cell studies, platelet count and bone marrow study that confirms the diagnosis and definitive therapy should not be instituted without it.

WHAT ABOUT TREATMENT?

Leukemia is still considered uniformly fatal but treatment methods have produced definite increases in survival time. Numerous potent drugs are available and expert consultants should be secured to share treatment and management responsibilities.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.



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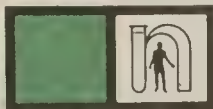
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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OCTOBER

Thirty-Ninth Annual Meeting of the American Academy of Pediatrics, October 17-22, 1970, San Francisco, California.

Fifty-Sixth Annual Clinical Congress of the American College of Surgeons, October 12-16, 1970, Chicago, Illinois.

Twenty-Third Annual Meeting of the American Association of Blood Banks, October 27-30, 1970, San Francisco Hilton, San Francisco, California.

Second Annual Scientific Assembly of the American College of Emergency Physicians, October 20, 1970, Hotel Sahara, Las Vegas, Nevada.

NOVEMBER

Conference on "Hyperglycemia and Nutrition in the Aged," November 4, 1970, Philadelphia Geriatric Center, Philadelphia.

Postgraduate course program on "Diagnostic Procedures in Gastroenterology," November 11 and 12, 1970, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Eleventh Annual Meeting of the American College of Nutrition, November 29, 1970, Boston, Massachusetts.

Nineteenth Annual Alumni Day of the Children's Hospital of Pittsburgh, November 13, 1970, Pittsburgh. The theme is "The Care of the Newborn Infant." For information contact: Lee W. Bass, M.D., Secretary, 3600 Forbes Avenue, Pittsburgh, Pennsylvania 15213.

Pennsylvania Medical Society Annual Scientific Assembly, November 16-19, 1970, Host Farm Resort Motel, Lancaster.

American Heart Association 43rd Scientific Sessions, November 12-15, 1970, Atlantic City Convention Hall, Atlantic City, New Jersey.

American Heart Association Annual Assembly, November 16-17, 1970, Shelburne-Dennis Hotels, Atlantic City, New Jersey.

American Heart Association 24th Annual Meeting Council on Arteriosclerosis American Society for the Study of Arteriosclerosis, November 10-11, 1970, Howard Johnson's Motor Lodge, Atlantic City, New Jersey.

DECEMBER

Twenty-Ninth Annual Meeting of the American Academy of Dermatology, December 5-10, 1970, Palmer House, Chicago, Illinois. For information contact: Frederick A. J. Kingery, M.D., Secretary-Treasurer, American Academy of Dermatology, 2250 Northwest Flanders, Portland, Oregon.

Seventh Annual Pulmonary Function Course, December 7-11, 1970, Tulane University School of Medicine, New Orleans, La. Contact Louisiana Thoracic Society, Suite 1504, 333 St. Charles St., New Orleans, La. 70130.

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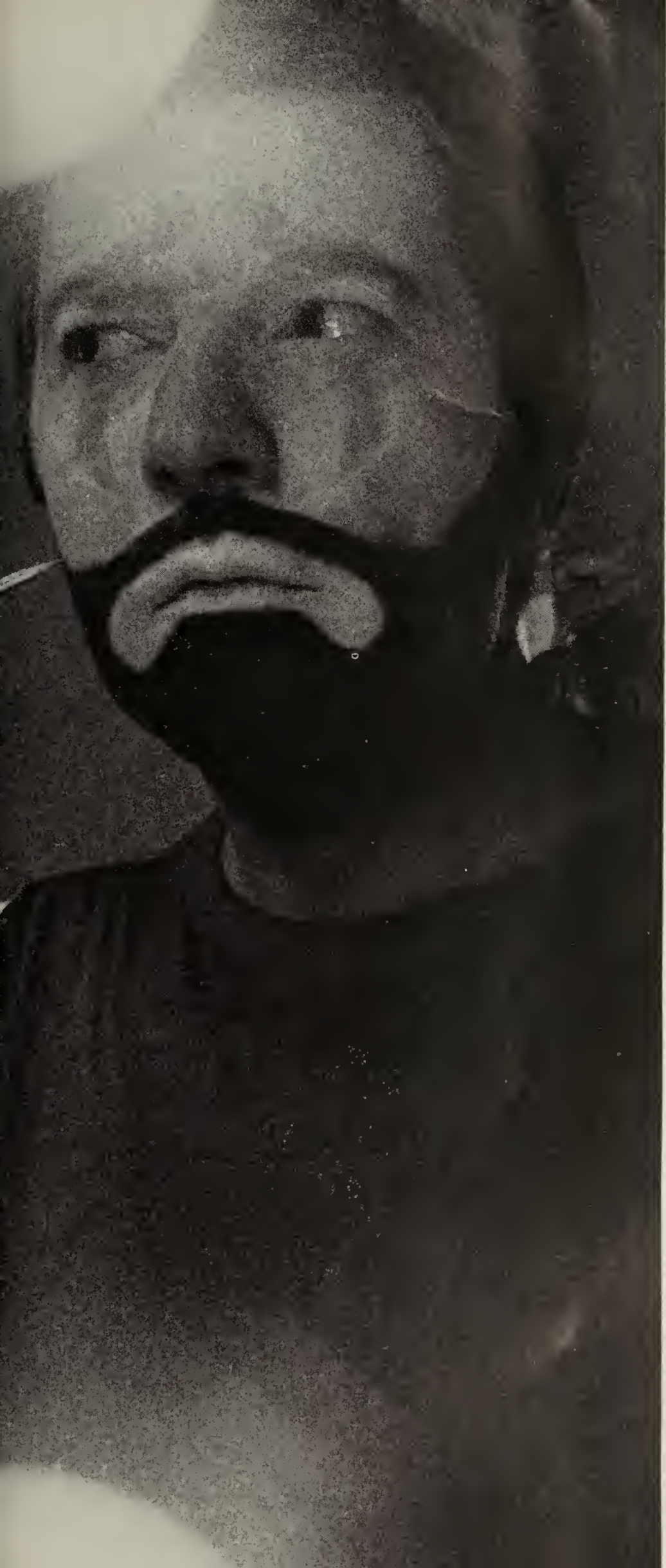
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Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

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Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

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For **Indications**, **Contraindications**, **Precautions**, **Side Effects** and **Dosage** see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

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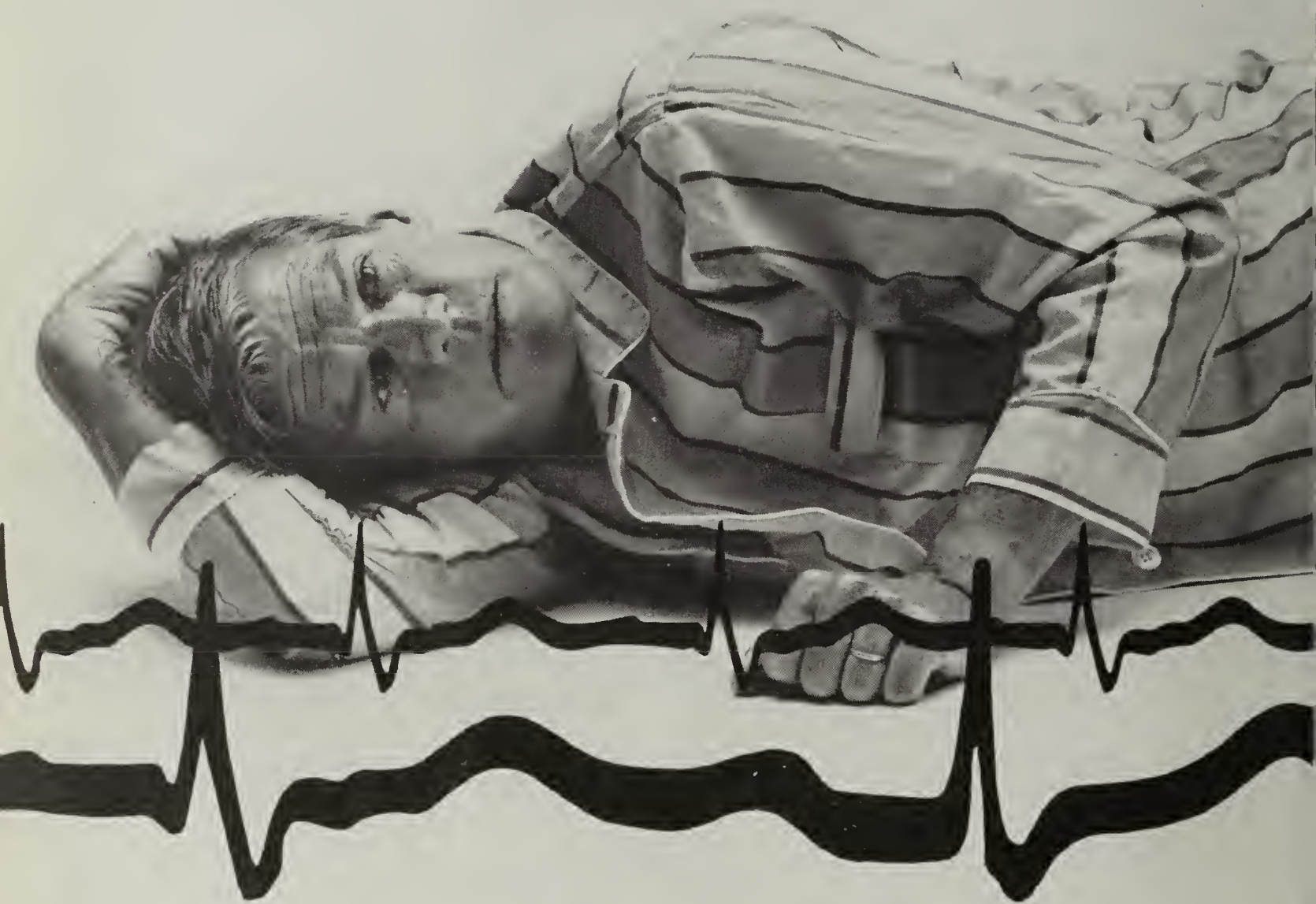
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Night of the Cardiac

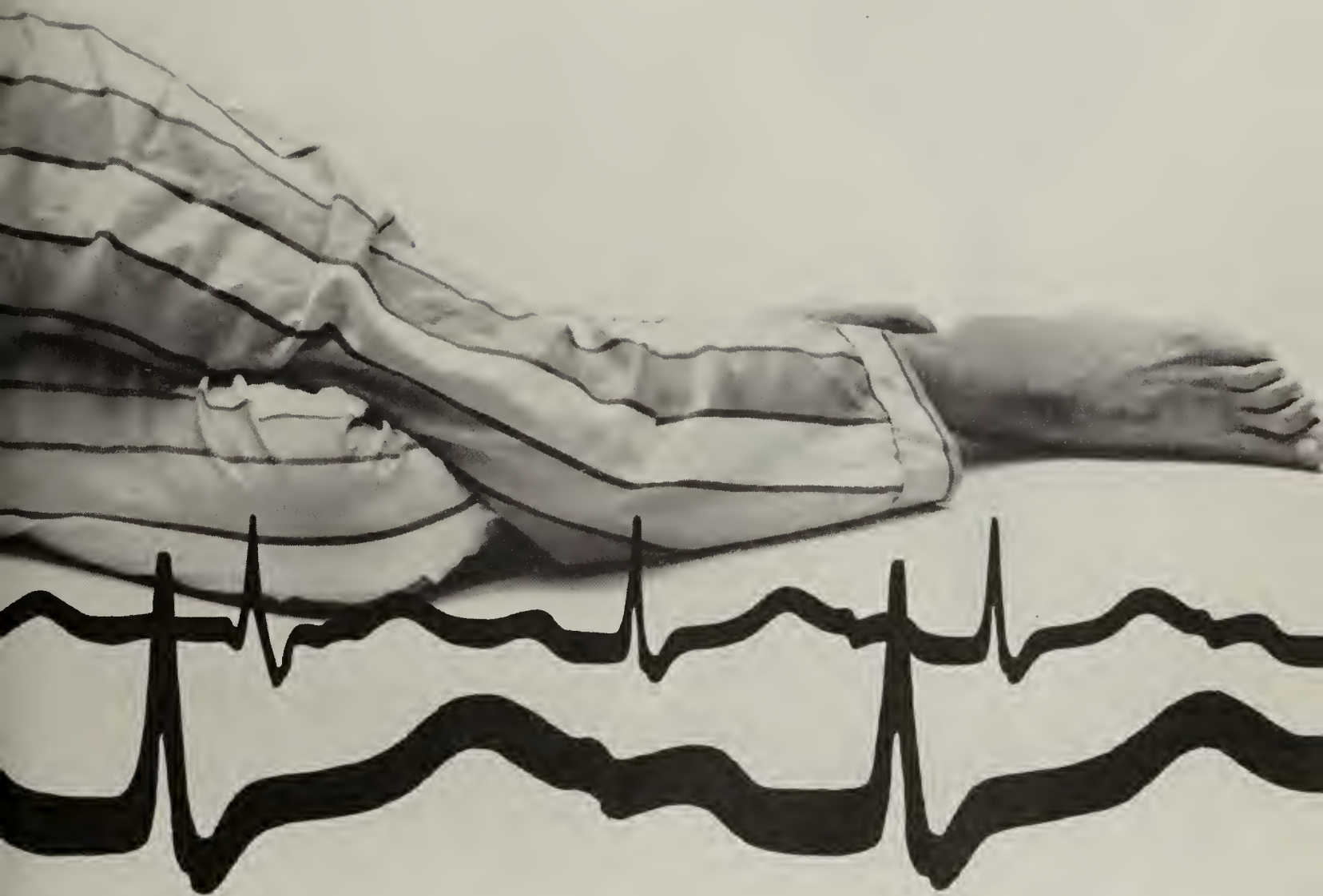


Sleeplessness may produce additional difficulties in victims of heart disease. This "cardiac insomnia" can debilitate the patient—particularly the geriatric heart patient—to such degrees as to cause reduction of stamina and endurance, with possible loss of some physiologic function. To further the problem, the heart patient often becomes a "sleep cripple" as he spends a good portion of the night listening to his heart beat with a morbid reluctance to fall asleep. When this problem remains unresolved, it may intensify his heart condition. It may even complicate treatment and delay recovery.

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WARNINGS: Caution patients about combined effects with alcohol
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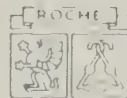
Physical and Psychological Dependence: Physical and psychological
dependence rarely reported. If withdrawal symptoms do occur
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and should be treated in the same fashion. Use caution in
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initiative. Repeat prescriptions should be under adequate
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Usage in Pregnancy: Weigh potential benefits in pregnancy, during
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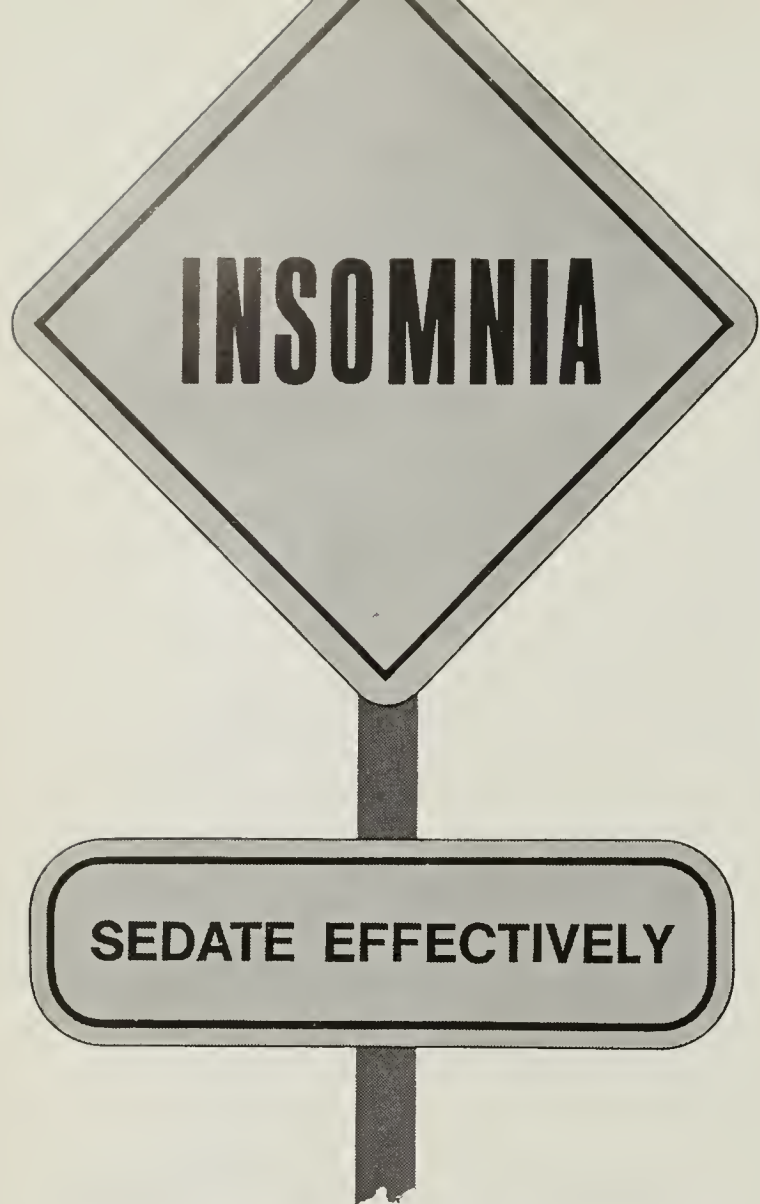
PRECAUTIONS: If sleeplessness is pain-related, an analgesic
should also be prescribed. Perform periodic blood counts if used
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not exceed 400 mg, as greater amounts do not significantly
increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have
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moderate gastric upset (including diarrhea, esophagitis, nausea and
vomiting), headache, paradoxical excitation and skin rash. There
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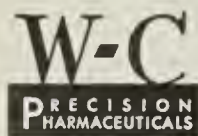
With QUI-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUI-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUI-A-ZONETM

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.

Usual Adult Dose: 1 to 2 tablets before retiring.

PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.



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new members

**These M.D.'s have joined the State Society
in recent months:**

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Kenneth B. DeBenedictus, M.D., 600 Museum Rd., Reading 19602

John F. Hiehle, M.D., The Reading Hospital, Reading 19602.

S. Neitz Siebert, M.D., The Reading Hospital, Reading 19602.

BLAIR COUNTY:

Stanton R. Brown, M.D., Altoona Hospital, Department of Pathology, Altoona 16603.

CHESTER COUNTY:

Pascal J. Imperato, M.D., 1555 Sugartown Rd., Paoli 19301.

DAUPHIN COUNTY:

Sherwood A. Cole, M.D., 309 Candlelight Dr., Camp Hill 17011.

Carl J. Dorko, M.D., 3513 Schoolhouse Lane, Harrisburg 17109.

Manuel F. Quesada, M.D., 1926 N. Second St., Harrisburg 17102.

Ronald M. Grossman, M.D., 1517 Cedar Cliff Dr., Camp Hill 17011.

Lawrence B. Silver, M.D., 2447 N. Third St., Harrisburg 17110.

DELAWARE COUNTY

Edward J. Zobian, M.D., 3508 Washington Ave., Brookhaven 19015.

ERIE COUNTY:

Paul H. Sandstrom, M.D., 105 Professional Building, Erie 16507.

LANCASTER COUNTY:

Ivan B. Leaman, M.D., 109 N. Decatur St., Strasburg 17579.

Stephen D. Lockey, III, M.D., 60 N. West End Ave., Lancaster 17603.

Harry L. Steffy, D.O., 1147 W. Main St., Ephrata 17522.

LAWRENCE COUNTY:

Petronio F. Zalamea, M.D., 731 Lawrence Ave., Ellwood City 16117.

LEHIGH COUNTY:

LeRoy S. Wolfe, M.D., 403 Barrett Rd., Emmaus 18049.

Sylvia Sussman, M.D., 3045 Whitehall St., Allentown 18104.

MONROE COUNTY:

Herbert A. Friedman, M.D., 175 E. Brown St., E. Stroudsburg 18301.
James A. Walsh, M.D., Monroe County General Hospital, Stroudsburg 18301.

MONTGOMERY COUNTY

Andres H. Andal, M.D., 635 Ardmore Ave., Ardmore 19003.
Jerry Gottlieb, M.D., 2775 Highland Ave., Broomall 19008.
Rosalie B. Kryston, M.D., 1109 Powell St., Norristown 19401.
Sigurd C. Sandzen, Jr., M.D., York and Keith Rds., Abington 19001.

NORTHAMPTON COUNTY

Donald H. Smith, M.D., Twenty-first and Fairview Aves., Easton 18042.

PHILADELPHIA COUNTY

John E. Pickering, M.D., 1929 E. Allegheny Ave., Philadelphia 19134.
Lewis P. Rowland, M.D., 3400 Spruce St., Philadelphia 19104.
Vasant N. Udhoji, M.D., 5555 Wissahickon Ave., Philadelphia 19144.
Alan E. Zimmer, M.D., 602 Washington Square, Philadelphia 19106.
Ronald J. Bolognese, M.D., 829 Spruce St., Philadelphia 19107.
Jose O. Morales, M.D., 271 St. Clair Dr., Moorestown, N.J. 08057.
Hartwell G. Thompson, Jr., M.D., 425 Timber Lane, Devon 19333.
Joel I. Polin, M.D., 914 Tustin St., Philadelphia 19111.
Robert John Bielen, M.D., 121 David Dr., Havertown 19083.
William Eliades, M.D., 1015 Chestnut St., Philadelphia 19107.
Robert Gibbon, Jr., M.D., 60 Bethlehem Pike, Philadelphia 19118.
Arthur S. Haber, M.D., 321 Warren Blvd., Broomall 19008.
James R. Hamsher, M.D., 4538 N. Hurley St., Philadelphia 19120.
Irwin Lyons, M.D., York & Township Line Rd., Jenkintown 19046.
Henry Scheuermann, M.D., 302 Powell Rd., Wynnewood 19096.
Nime Tchourumoff, M.D., 518 W. Girard Ave., Philadelphia 19123.

VENANGO COUNTY

Frederico A. Padin, M.D., 1263 Elk St., Franklin 16323.

WASHINGTON COUNTY

Anthony S. Galletta, M.D., 103 Bluff St., Canonsburg 15317.
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PENNSYLVANIA MEDICINE



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-gripping. Chewable. Very palatable. Economical.

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A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.

PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C
PRECISION
PHARMACEUTICALS

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○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ Joseph A. Gilmartin, Pittsburgh; University of Pittsburgh School of Medicine, 1920; age 74; died July 12, 1970. Dr. Gilmartin was a nationally known pediatrician and past president of the Pittsburgh Pediatric Society. Survivors include his wife, a daughter and a son.

○ William B. Griggs, Jenkintown; Hahnemann Medical College, 1894; age 98; died June 18, 1970. He was a former president of the International Hahnemannian Association and had received recognition from the city of Philadelphia for his services to the health and welfare of the community. His wife survives.

○ Albert Hudacek, Canonsburg; Jefferson Medical College, 1924; age 70; died June 26, 1970. He was a member of the Canonsburg General Hospital medical staff where he also served as a past president. His wife, a daughter and a son survive.

○ Laimons E. Vanags, Butler; Faculty of Medicine, University of Leiden, Netherlands, 1951; age 49; died July 17, 1970. His mother and two daughters survive.

○ Louis S. Kaplan, Philadelphia; Thomas Jefferson University School of Medicine, 1938; age 57; died July 8, 1970. He was associated with the Einstein Medical Center and was a professor at the Medical College of Pennsylvania. He was the author of numerous articles on psychiatry and psychoanalysis. Surviving are his wife, a son and three daughters.

○ Hyman S. Liebling, Pittsburgh; Universitat Zurich Medizinische Fakultät, 1938; age 61; died July 6, 1970. He is survived by his wife, two daughters and a son.

○ Nathaniel S. Riskof, Philadelphia; University of Pennsylvania School of Medicine, 1928; age 66; died April 3, 1970. His wife survives.

○ Charles F. Strunk, Philadelphia; Thomas Jefferson University School of Medicine, 1942; age 52; died March 19, 1970. He is survived by his wife, a son and a daughter.

○ James S. Taylor, Jr., Altoona; Johns Hopkins University School of Medicine, 1943; age 54; died June 27, 1970. He was director and the chief of gynecology and obstetrics at Altoona Hospital. Surviving are his wife and four children.

○ Henry F. Adams, North East; Boston University School of Medicine,

1918; age 77; died June 11, 1970. Survivors include his wife, a son, Melvin L. Adams, M.D., and two daughters.

○ Walter L. Anders, Jr., Bethlehem; University of Rochester School of Medicine and Dentistry, 1952; age 47; died June 26, 1970. He specialized in psychiatry and neurology. His wife, three sons and four daughters survive.

○ Forrest J. Bovard, Los Angeles, Calif.; Thomas Jefferson University School of Medicine, 1897; age 95; died June 18, 1970. Two daughters survive.

○ Robert F. Cooney, Mayfield; University of Maryland School of Medicine, 1937; age 62; died July 16, 1970. Surviving are his wife, two daughters and a son.

○ David A. Cooper, Wynnewood; University of Pennsylvania School of Medicine, 1921; age 72; died July 6, 1970. He was emeritus professor of medicine at the University of Pennsylvania and served as a consultant on pulmonary diseases for the Veterans Administration. Dr. Cooper had also served as president of the Philadelphia County Medical Society, and received the 1970 Strittmatter Award of that society last May. Surviving are his wife and three daughters.

○ Derek H. Cross, Greensburg; McGill University Faculty of Medicine, 1940; age 50; died July 6, 1970. He was a past president of the Pennsylvania Academy of Physical Medicine and the first medical director of the Harnmarville Rehabilitation Center. He is survived by his wife and two sons.

○ Dominic D' Angelo, Hazleton; University of Naples School of Medicine, 1927; age 68; died June 26, 1970. He conducted a tuberculosis clinic in Hazleton. His wife survives.

○ John D. Denny, Columbia; University of Pennsylvania School of Medicine, 1919; age 77; died June 26, 1970. He was a former president of the Lancaster City and County Medical Society. Surviving are his wife and son.

○ George V. Derickson, Mount Dora, Fla.; Hahnemann Medical College, 1938; age 58; died June 22, 1970. His wife survives.

○ Raymond A. D. Gillis, Pittsburgh; McGill University School of Medicine, 1913; age 83; died July 11, 1970. He is survived by a son and daughter.

Lemuel C. Alcorn, North East; George Washington University School of Medicine, 1933; age 65; died March 21, 1970. His wife survives.

Guy E. Dutter, Kane; University of Pennsylvania School of Medicine, 1917; age 76; died July 3, 1970. His wife and brother survive.

George M. Klitch, Harrisburg; Hahnemann Medical College, 1939; age 60; died July 6, 1970. He was a member of the staff of Polyclinic Hospital. Surviving are his wife and daughter.

Florence B. Kordasz, Philadelphia; The Medical College of Pennsylvania, 1959; age 38; died March 14, 1970. Her parents survive.

Frances K. Lukes, York; University of Pittsburgh School of Medicine, 1969; age 26; died March 16, 1970. Her parents survive.

Frank E. Fishof, Wilkes-Barre; University of Louisville, 1926; age 72; died August 9, 1970. He was a member of the American Academy of Ophthalmology and Otolaryngology. His wife and two daughters survive.

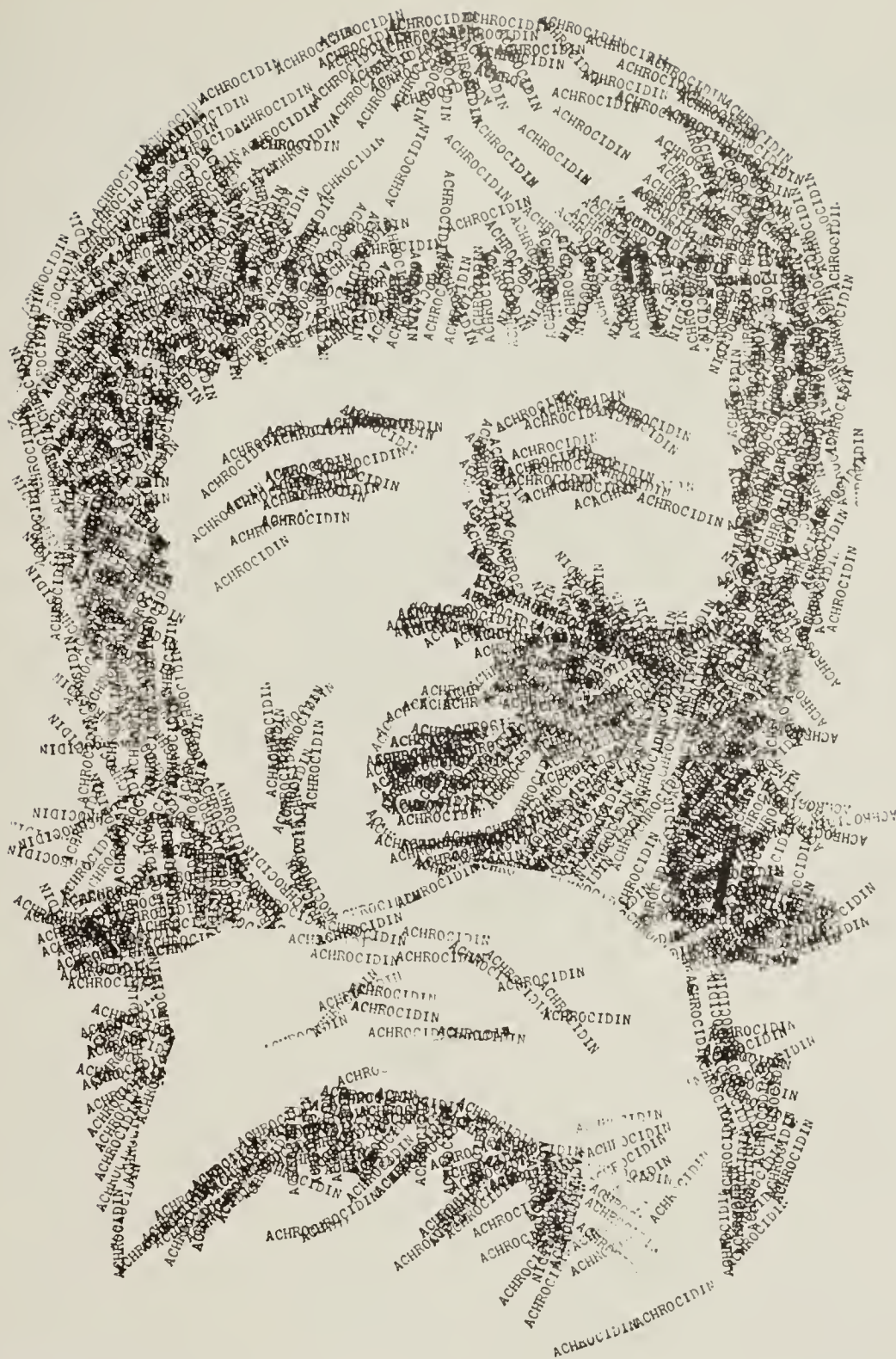
Walter G. Kilbury, Bradford; University of Michigan School of Medicine, 1925; age 70; died May 29, 1970. No survivors are listed.

Marjan Kostowiecki, Philadelphia; University of Jana Kazimierza Wydział Lekarski, Lwow, Poland, 1928; age 66; died August 20, 1970. He was an anatomy professor at the University of Pennsylvania School of Medicine and had published many papers in his field. No survivors are listed.

Romulo A. Terrero, Philadelphia; Facultad de Medicina Universidad Central de Venezuela Ciudad Univ., Caracas, Venezuela, 1963; age 30; died August 1, 1970. There are no survivors listed.

Joseph F. Matonis, Schuylkill-Haven; Temple University School of Medicine, 1934; age 63; died July 2, 1970. Surviving are his wife, two daughters and a son.

Theodore Tsaltas, Philadelphia; University of Athens Medical School, 1951; age 47; died August 15, 1970. He was a former advisor to the Greek Royal Court under King Paul and more recently served as a professor of pathology at the Thomas Jefferson University Medical Center. In 1968 he received a citation for his research in biomedicine from the Philadelphia County Medical Society. His wife, Margaret Owen Tsaltas, M.D., a son and a daughter survive.



Achrocin[®] Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN[®] Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons

on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculo-

papular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

CARDIOVASCULAR DISEASE

May 6-7, 1971; Pittsburgh

C-PRE-INFARCTION PATIENT; by Pa. Heart Assoc.; at Chatham Center; 7 hrs. ea. day; 14 hrs. AAGP credit applied for; \$25 fee. Contact Royce J. Britton, Prg. Dir., Pa. Heart Assoc., P. O. Box 2435, Harrisburg 17105.

CHEST DISEASES

November 30-December 11, 1970; Philadelphia (Hahnemann)

O/AMA-A WORKSHOP IN RESPIRATORY INTENSIVE CARE; by Greater Delaware Valley Regional Medical Program; 10 consecutive days; 8 hrs. ea. day; max. registration-15; 80 hrs. AAGP credit applied for. Contact R. F. Johnston, M.D., Head, Sect. of Chest Diseases, Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 3-14, 1970 and March 1-12, 1971; Philadelphia

PG-POSTGRADUATE COURSES IN BRONCHOESOPHAGOGY; at Temple. Contact Charles M. Norris, M.D., Chvalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

November 11, 1970; Franklin

C/AMA-CURRENT CONCEPTS OF DIABETES MELLITUS; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 10, 1971; Sharon

C/AMA-MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

October 6, 1970; Host Farm Resort Motel, Lancaster

November 11, 1970; Philadelphia County Medical Society

November 1970; Philadelphia County Medical Society

March 1971; Berks Co. Med. Soc., Reading
April 14, 1971; William Penn Hotel, Pittsburgh

May 1971; Conemaugh Valley Mem. Hosp., Johnstown

June 1971; Lehigh Valley Club, Allentown

O-MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit

CODE KEY

C - Consecutive days

I - Intermittent

O - Circuit

PG - Postgraduate Traineeship

S - Designed for full-time specialists

AMA-AMA Accredited Institution

CES - Council on Education and Science, Pennsylvania Medical Society

Hahnemann - Hahnemann Medical College and Hospital

Hershey - Milton S. Hershey Medical Center

Jefferson - Jefferson Medical College of Philadelphia

Penn-Grad - University of Pennsylvania, Division of Graduate Medicine

Pitt - University of Pittsburgh School of Medicine

Pitt P.H. - University of Pittsburgh Graduate School of Public Health

Penn State - Pennsylvania State University

Temple - Temple University Health Sciences Center

U. of Pa. - University of Pennsylvania School of Medicine

Woman's - The Medical College of Philadelphia

\$5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

Pittsburgh; September 9-October 14, 1970

I-SELECTED SHORT SUBJECTS IN MEDICINE; at Pitt, two days ea. week, 5½ weeks; 3 hrs. a day; \$25 fee. Contact Ronald A. Chez, M.D., Assoc. Dean, Academic Affairs Pitt.; 3550 Terrace St., Pittsburgh 15213.

Pottsville; September 24, 1970-May 27, 1971

I/AMA-CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Sewickley Valley Hospital; October 14-November 11, 1970

I-MEDICAL-SURGICAL EMERGENCY CARE; by Pitt; every Wed.; 5 weeks; 3½ hrs. ea. day; AAGP credit requested; \$40 fee (\$10 per single session). Contact Ronald Chez, M.D., Assoc. Dean, Academic Affairs, Pitt.; 3550 Terrace St., Pittsburgh 15213.

Lancaster Osteopathic Hosp.; October 8, 1970-March 11, 1971

I/AMA-CONTINUING MEDICAL EDU-

CATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602.

October 29-31, 1970; Champion

I/AMA-MEDICAL RETREAT (variety of provocative medical subjects); by Jefferson and Conemaugh Valley Mem. Hosp. (Johnstown); at Seven Springs Resort Hotel; 18 hrs. AAGP credit requested; \$45 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lebanon; November 3, 1970-May 4, 1971

I/AMA-A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 16-19, 1970; Lancaster

C-CLINICAL THERAPEUTICS 1970: EMERGENCY MEDICINE (1970 Scientific Assembly of PMS); by CES; at Host Farm Resort Motel. Contact Robert L. Evans, M.D., CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

December 7-11, 1970; Philadelphia

C/AMA-EMERGENCY ROOM CARE (I Physicians); by Hahnemann; at Marriott Motor Hotel; 25 hrs. AAGP credit applied for; \$125 fee. Contact Wilbur W. Oaks, M.D., Prg. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 3, 1971; Harrisburg

C-DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

INTERNAL MEDICINE

Johnstown; September-November, 1970
Kittanning; September-November, 1970
Meadville; September-November, 1970
New Castle; September-November, 1970
Pittsburgh; September 16-December 9, 1970
Pittsburgh; September 17-December 10, 1970

I-SEMINARS IN PATIENT CARE; at Staunton Clinic; 2 hrs. a day; 1 day a week; 13 weeks; \$100 fee; Max. regis.: 15; 26 hrs. AAGP credit approved. Contact Rex A. Pittenger, M.D., Chief Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

York Hospital; September 17, 1970-April 29, 1971

I-AMA-A PROGRAM OF CONTINU-

ING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; \$40 fee (\$8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 14, 1970—May 12, 1971; Philadelphia

I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; \$150 fee (\$70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 26-28, 1970; Philadelphia

C/AMA—NEW CONCEPTS IN BASIC AND APPLIED HEMATOLOGY; by Amer. Coll. of Physicians; at Jefferson; min. registration 50; max. registration 150; \$80 fee for ACP members (\$125 non-members). Contact Edward C. Rosenow, Jr., M.D., Exec. Dir., Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

MALIGNANT DISEASE

November 16-19, 1970; Philadelphia

C/AMA—CANCER CHEMOTHERAPY (2nd Symposium) by Hahnemann; at Sheraton Hotel; 26 hrs. AAGP credit applied for; \$125 fee. Contact Isadore Brodsky, M.D., Prg. Dir., Hahnemann; 230 N. Broad St., Philadelphia 19102.

OBSTETRICS & GYNECOLOGY

October 30, 1970; Darby

C/AMA—MENSTRUAL DYSFUNCTION; by Jefferson and Mercy Catholic Med. Center; \$20 fee. Contact J. Edward Lynch, M.D., Mercy Catholic Med. Center, Darby 19023.

December 3 and 4, 1970; Philadelphia

C/AMA—OFFICE GYNECOLOGY; two-day seminar; by Jefferson; at McClellan Hall; \$40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1971; Hershey Motor Lodge

C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; \$10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

PEDIATRICS

November 4-6, 1970; Children's Hosp. of Philadelphia

C—RESPIRATORY FAILURE IN INFANTS AND CHILDREN; by Amer. Acad. of Pediatrics, U. of Pa. and Children's Hosp.; 20 hrs. Contact Leonard Bachman, M.D., Course Coordinator, Children's Hosp., 1740 Bainbridge St., Philadelphia 19146.

PHARMACOLOGY

October 15, 1970; Harrisburg

C/AMA—THE PHARMACOLOGY OF

MARIJUANA AND ADDICTIVE DRUGS; by Hahnemann; at Academy of Medicine; 2 hrs. Contact Joseph Garfunkel, M.D., Polyclinic Hosp., Harrisburg, 17105.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park

C—SPORTS MEDICINE CONFERENCE; by CES and Penn State. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.

Altoona Hospital; fourth Thurs. ea. mo.

Greensburg (Westmoreland Hosp.); first Tues. ea. mo.

Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.

Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.

Uniontown Hospital; last Mon. ea. mo.

Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971

I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Educational Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 20, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES;

alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

DuBois Hospital; February 4—April 8, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazleton State Gen. Hosp.; September 2, 1970—May 26, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazleton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazleton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster Gen. Hosp.; September 22, 1970—May 18, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17602.

Lebanon; November 3, 1970—May 4, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14—December 2, 1970

I—RECENT ADVANCES IN MEDICINE; at Temple; 1 day ea. week; 32 hrs. AAGP credit applied for; \$50 fee. Contact Albert J. Finestone, M.D., Clin. Prof. of Med. Temple, 3400 N. Broad St., Philadelphia 19140.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions

Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840. Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grand View Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 hrs. AAGP credit applied for. \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS—CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for; \$25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September—November, 1970 and February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 10 weeks ea. semester; 40 hrs. AAGP credit applied for; \$25 fee ea. semester. Contact J. Martin Myers, MD., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September 24–December 3, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; every Thurs.; 10 weeks; 20 hrs. AAGP credit requested. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Norristown; September–November, 1970

I—THE PRE-SCHOOL CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics; 2 hrs. ea. day; 1 day ea. week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown; March–May, 1971

I—THE LATENCY AGE CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hrs. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia, 19139.

Philadelphia; September 30–December 2, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 20 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 6–December 15, 1970

I/S—BEHAVIOR THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Hosp. of U. of Pa.; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8–December 24, 1970

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF ALCOHOLISM, DRUG ADDICTION AND SEXUAL PROBLEMS; at The Institute of Pennsylvania Hospital; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970–April 6, 1971

I—MEDICAL HYPNOSIS; by The Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; \$150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 12–December 14, 1970

I/S—FAMILY THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Phila. Child Guidance Clinic; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13–December 15, 1970

I/S—MARITAL THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at the Phila. Marriage Council; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 14, 1970–March 3, 1971

I/AMA—PSYCHIATRIC PROBLEMS OF CHILDREN; at Hahnemann; every Wed. (except holidays); 18 weeks; 36 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. of Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 21, 1970–June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; \$75 fee for 10-week session, \$150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 26–December 14, 1970

I/S—THERAPY OF PROBLEMS IN SEXUAL ADJUSTMENT; by The Institute of Pennsylvania Hospital and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 7–March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS; at The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February–April, 1971

I/S—TREATING SEXUAL INADEQUACY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March–April, 1971

I/S—PSYCHOPHARMACOLOGY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. ea. day; 1 day a week; 8 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March–May, 1971

I/S—DRUG ABUSE AND ACUTE PSYCHOSIS; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 24–May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; April 7–May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; \$50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

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**PENNSYLVANIA
 MEDICINE**

correspondence

Open Letter To Blue Shield II

It has been nearly two years since publication of our initial "Open Letter to Blue Shield."

As you may recall, our original commentary was critical of many of Blue Shield's policies and administrative practices which intrude upon the prerogatives of private medical practice and tend to damage doctor-patient relationships. Publication of the open letter was followed by publication of a rebuttal by Blue Shield's fee schedule chairman. Blue Shield's rebuttal apparently missed the satirical nature of the open letter and presented a rather legalistic recital of Blue Shield's policies which answered none of our criticisms.

Our mail following publication of the letter would seem to indicate that we were not alone in deriving no distinction between intimidation of private practice by Blue Shield or by the federal government.

The Pennsylvania Medical Society, by its support of a prevailing fee program for Blue Shield and particularly in its support of such a program for the medical assistance program, has given us some ground for optimism. Similarly, the recent announcement that Blue Shield's old participating doctor agreements are obsolete appears realistic and many of us look forward to a similar announcement for Blue Shield's service benefit policies.

In the face of a reluctance by many of us to enter a new participating doctor agreement with Blue Shield, it might be appropriate for Blue Shield to finally turn its attention to

the aggravations outlined in the original "open letter":

1. Sale of service benefit policies to middle and upper income families without regard to, or prior investigation of, income.
2. Sale of Blue Shield contracts to industry without apparent regard that these contracts are used as bargaining instruments with labor—often with a tendency toward exaggeration of actual benefits.
3. Inefficient Blue Shield office procedures and communication resulting in frustration and exasperation for physicians attempting to intercede for patients.
4. Inefficient investigation of service benefit disputes resulting in damage to the doctor-patient relationship.
5. Misleading advertising giving the impression of Blue Shield being a "Doctors' Plan" but with no apparent credit given to medicine for the charity involved in Service Benefit cases. The impression is given of everything paid in full.
6. Intrusion into doctor-patient relationships, particularly in service benefit cases and often following inefficient investigation of need for service benefits.
7. Fee schedule inequities.

We continue to hold respect and optimism for the private practice of medicine but feel that its continued existence is dependent upon excellence in private care and not upon dispensation of cut-rate care by third parties.

Ralph J. Miller, M.D.
 Indiana, Pennsylvania



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and sometimes I cry.”**

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(Please see last page for full adverse reactions, contraindications, warnings and precautions.)

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nervous, tired
all the time
and always
nagging.”

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lack of energy
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The antianxiety effect of Sinequan (doxepin HCl) was compared to that of either diazepam or chlordiazepoxide in ten double-blind studies^{1,2} of 422 patients with psychoneurotic anxiety. An analysis of the symptom rating scales revealed that Sinequan was unsurpassed by the two tranquilizers in treating a broad range of anxious symptomatology.

Global evaluation of the double-blind studies also expressed the comparative effectiveness of Sinequan:

SINEQUAN VS. CHLORDIAZEPOXIDE IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	CHLORDIAZEPOXIDE
TOTAL NO. OF PATIENTS	77	72
NUMBER IMPROVED	64	56
MARKED	21	7
MODERATE	27	23
SLIGHT	16	26
% IMPROVED	83%	78%

SINEQUAN VS. DIAZEPAM IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	DIAZEPAM	PLACEBO
TOTAL NO. OF PATIENTS	118	102	48
NUMBER IMPROVED	100	75	33
MARKED	47	34	12
MODERATE	29	29	11
SLIGHT	24	12	10
% IMPROVED	85%	74%	69%

Overall evaluations¹ of patients treated with Sinequan revealed that:

- 84% of 263 patients with symptoms of anxiety showed marked, moderate, or slight improvement
- 87% of 40 patients with symptoms of anxiety accompanying organic disease showed marked, moderate, or slight improvement
- 83% of 142 patients with symptoms of anxiety and depression showed marked, moderate, or slight improvement.

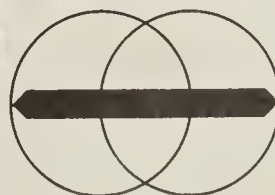
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to moderate anxiety



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an antidepressant.
The antidepressant that
is a tranquilizer.

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Kasich, A. M.: Psychosomatics Supplement 10:18, May-June, 1969.

(Please see last page for full adverse reactions, contraindications, warnings and precautions.)



Analysis of standard symptoms rating scales¹ proved the effectiveness of Sinequan (doxepin HCl) in decreasing the intensity and incidence of the most prevalent psychoneurotic symptoms:

Symptom	Improvement with Sinequan
Anxious Mood	74% (59 of 80 patients ^a)
Fears	73% (48 of 66 patients ^a)
Difficulty in decision-making	63% (12 of 19 patients ^b)
Tension	79% (63 of 80 patients ^a)
Depressed Mood	72% (50 of 69 patients ^a)
Loss of interest	73% (11 of 15 patients ^c)
Social Withdrawal	62% (13 of 21 patients ^b)
Somatic Symptoms (General)	76% (31 of 41 patients ^a)
Respiratory Symptoms	83% (19 of 23 patients ^a)
Gastrointestinal Symptoms	77% (54 of 70 patients ^a)
Cardiovascular Symptoms	67% (14 of 21 patients ^a)
Insomnia	73% (53 of 73 patients ^a)

Rating scales used for symptom evaluation

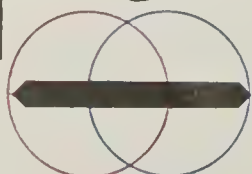
- a. Hamilton Anxiety Scale (Modified)
- b. Wittenborn Symptom Rating Scale
- c. Anxiety Check List

Effective control of anxiety's most prevalent psychic and somatic symptoms... relief of underlying depression

Sinequan[®]
DOXEPIN HCl



Starting dosage:
25 mg. t.i.d. for mild to moderate anxiety



Sinequan (doxepin·HCl) Capsules

Description. Sinequan (doxepin·HCl) is a new dibenzoxepin psychotherapeutic agent with marked antianxiety and significant antidepressant activity.

Chemistry. Sinequan (doxepin·HCl) is a dibenzoxepin derivative and is the first of a new family of psychotherapeutic agents. Specifically, it is an isomeric mixture of N,N-Dimethyl-dibenz(b,e)-oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.

Indications. In a carefully designed series of controlled studies, Sinequan (doxepin·HCl) has been shown to have marked antianxiety and significant antidepressant activity. Sinequan (doxepin·HCl) is recommended for the treatment of:

- (1) Patients with psychoneurotic anxiety and/or depressive reactions.
- (2) Mixed symptoms of anxiety and depression.
- (3) Alcoholic patients with anxiety and/or depression.
- (4) Anxiety associated with organic disease.
- (5) Psychotic depressive disorders including involuntal depression and manic-depressive reactions.

The target symptoms of psychoneurosis that respond particularly well to Sinequan (doxepin·HCl) include anxiety, tension, depression, somatic symptoms and concern, insomnia, guilt, lack of energy, fear, apprehension and worry.

In those patients in whom anxiety masks the depressive state, Sinequan (doxepin·HCl) is of particular value since it exerts a potent antidepressant effect as well as antianxiety activity.

Patients who have failed to respond to other antianxiety or antidepressant drugs may benefit from treatment with Sinequan (doxepin·HCl).

Clinical experience has shown that Sinequan (doxepin·HCl) is safe and well tolerated even in the elderly patient.

In a large series of patients systematically observed for withdrawal symptoms, none were reported. This is consistent with the virtual absence of euphoria as a side effect and the lack of addiction potential characteristic of this type of chemical compound.

Contraindications. Sinequan (doxepin·HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin·HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin·HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin·HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitor should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin·HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of the possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin·HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzazocycloheptenes) are capable of blocking the effects of guanethidine and similar acting compounds in both the animal and man. Sinequan (doxepin·HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin·HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin·HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin·HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

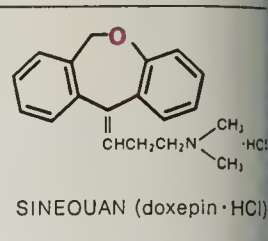
In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin·HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

References: 1. Data on File, Medical Research Laboratories, Pfizer Pharmaceuticals, Pfizer Inc., Groton, Conn. 2. Pitts, N.E.: Psychosomatics 10:164, May-June, 1969.



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NOVEMBER, 1970

MEDICAL EDITOR CARL B. LECHNER, M.D.,
STATE SOCIETY PAST PRESIDENT, DIES

Carl B. Lechner, M.D., of
Erie, honorary past presi-
dent of the Pennsylvania

Medical Society and medical editor of PENNSYLVANIA MEDICINE, died
October 13 at his home in Erie following an illness of more than a
year. Medical editor of the Society's journal for twelve years, Dr.
Lechner was elected president-elect of the State Society in 1968.
He resigned that office just prior to the 1969 Annual Session of
the House of Delegates because of illness. Having served as presi-
dent-elect, he was made an honorary past president of the State
Society, and accorded the full honors of that office. As a memo-
rial to Dr. Lechner, the family has suggested bequests to the Penn-
sylvania Medical Society Educational Fund, 20 Erford Road, Lemoyne
17043.

NEW OFFICERS ASSUME DUTIES;
PMS DUES STAY UNCHANGED

The PMS House of Delegates in ses-
sion last month elected new officers
(see related story on page 21), and

approved retaining the current \$75 annual dues for active membership
in the State Society. It approved a 1971 budget which projects a
deficit of approximately \$19,000. The Finance Committee warned the
delegates that increased costs will undoubtedly result in a recom-
mendation for a dues increase to the 1971 House if even the current
level of activity is to be maintained. Later in the session the
Reference Committee on Public Service noted in its concluding re-
marks that its "deliberations were adversely influenced by the So-
ciety's budgetary restrictions which made it difficult for your
Reference Committee to fulfill its complete responsibilities."

HOUSE OF DELEGATES APPROVES
EDUCATION REQUIREMENT

The PMS House of Delegates, reject-
ing a Reference Committee recommen-
dation, approved a minimum education

requirement as a qualification for membership in the Pennsylvania
Medical Society, and asked county medical societies to take the
same step. The Committee on Constitution and Bylaws was directed to
prepare appropriate amendments for consideration at the 1971 Annual
Session. If each step in the development of criteria is on schedule,
the continuing education requirement for membership would be effec-
tive in 1975. By mid-1975, physicians who have not completed at
least 150 hours of specified continuing education in the preceding
three-year period would be ineligible for PMS membership. Details
will appear in later issues.

CONTINUING EDUCATION
INSTITUTE ENDORSED

Pennsylvania Medical Society leadership in
establishing a state-wide institute for con-

tinuing medical education was endorsed by the House of Delegates, which directed the Council on Education and Science to develop the details of a specific plan to establish the institute. The purpose of the institute would be to coordinate continuing education activities throughout the state. It would evaluate physician needs, correlate various programs and "innovate appropriate educational tools and mechanisms" to find the most effective continuing education approach.

STATEWIDE CARE FOUNDATION CONCEPT APPROVED BY HOUSE The House approved the concept of a Pennsylvania Medical Care Foundation and directed the Council on Medical Service to proceed with developing a specific program to be presented at the next meeting of the House of Delegates. The Council on Medical Service proposed a foundation patterned after the Sacramento County Medical Society Foundation for Medical Care following a directive from the 1969 House of Delegates that there be developed a program "in the best interests of both patients and physicians" in the face of the growing pressures for national health insurance. The foundation would be a prepaid closed panel but its enrollment would be on a statewide basis, including Medicare beneficiaries. The foundation would establish the conditions of participation for both physicians and hospitals and would offer full fee reimbursement on the 90th percentile rather than Medicare's 80 per cent of the 75th percentile. Specifics of the plan are slated to be presented to the 1971 Annual Session.

HOUSE OF DELEGATES SUPPORTS PREPAID GROUP GUIDELINES The House of delegates concurred with Board of Trustees approval of guidelines submitted by Pennsylvania Blue Shield for the establishment of prepaid group practice programs in the Commonwealth. It added that the approval should not be construed as supporting prepaid group practice to the exclusion of other types of practice. The guidelines submitted by Blue Shield were broad and would provide a base for discussion with physician groups interested in the possibilities of involving Blue Shield in per capitation group practice arrangements.

HOUSE REITERATES 1967 ABORTION POLICY The House of Delegates refused to support a recommendation of the Board of Trustees that the Society support a bill currently before the Legislature defining a legal abortion as one performed by a physician or a person acting directly under the supervision of a physician. Since the bill has no other stipulations, opponents felt it would create "abortion on demand." There was agreement that the present law is vague and the House finally took action to request amendment of the bill now before the Legislature to establish circumstances under which an abortion performed by a physician or person acting directly under his supervision would be legal. The circumstances approved by the House would specify medical reasons for performing an abortion--a threat to the life or health of the mother or the likelihood of gross deformity to the fetus, and that it be performed in an institution approved by the Joint Commission on Hospital Accreditation.

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■ to help restore
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the intestinal flora

■ for fever blisters
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Introduced to help reestablish the normal physiology of the intestinal tract in gastrointestinal disturbances¹, particularly diarrheas (including those resulting from antibiotic therapy), Lactinex is also useful for reestablishing the flora following bowel surgery, infant colic, mucous colitis, foul-smelling stools, pruritus ani, flatulence and hives.^{2,3,4,5,6}

Lactinex contains a viable mixed culture of both *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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- (1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

PENNSYLVANIA MEDICINE

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NOVEMBER, 1970

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it doesn't let monilia begin
where bacteria end.

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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin— maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney— rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions— urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.



Guide his hand to quality and economy

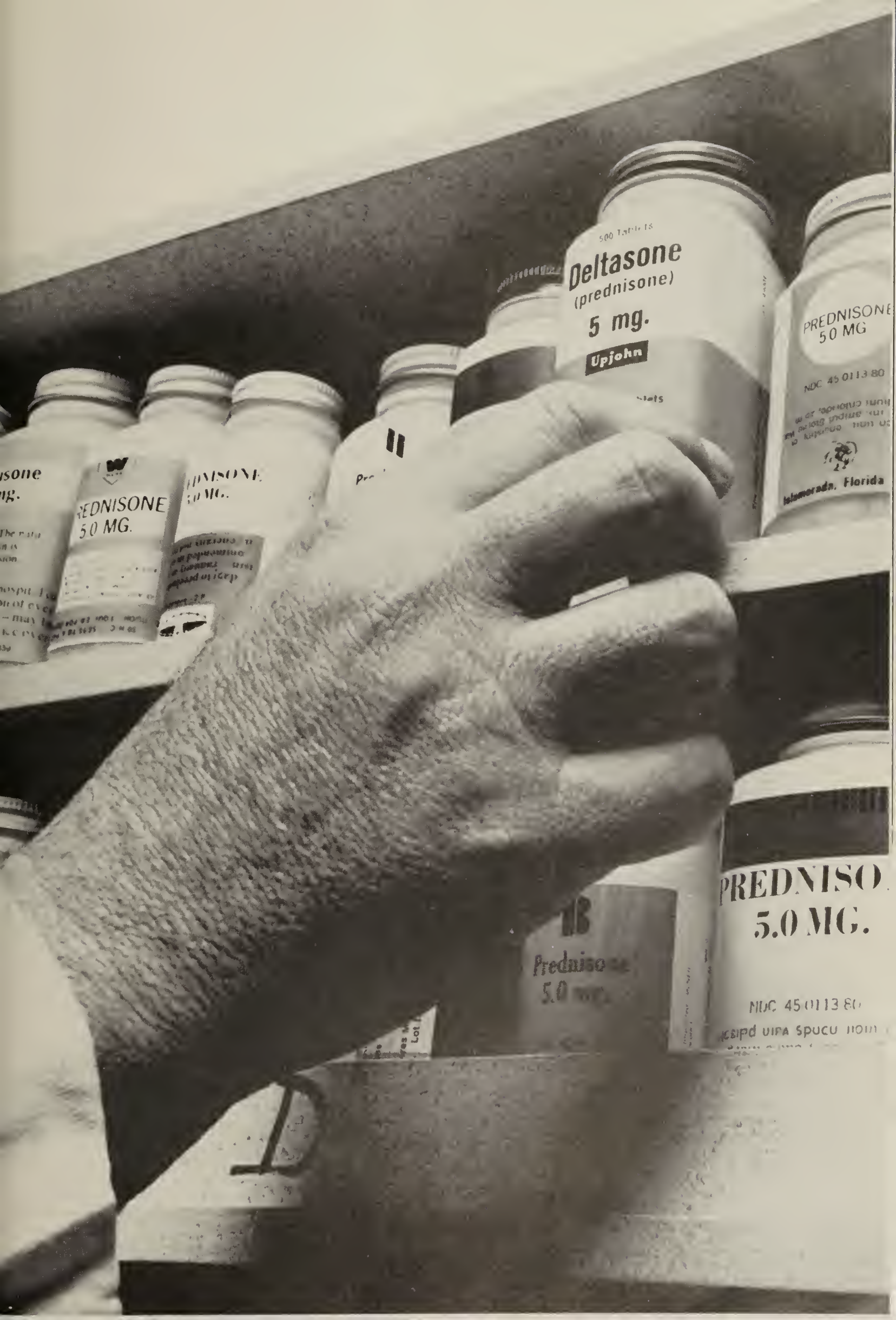
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance

doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9- α -fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

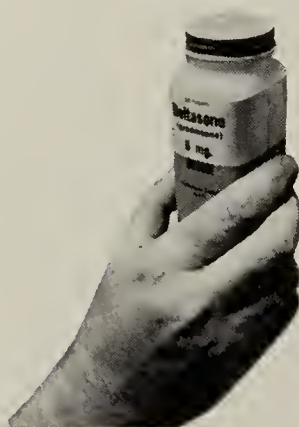
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prednisone
that's made
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William A. Limberger, M.D. Accepts PMS Presidency

*'Men act . . . in light of
the future . . . But their
search for a useable future . . .
will be grounded in their view
of particular pasts.'*



I would like to take this opportunity to express my appreciation to the members of the House of Delegates for the honor of being elected President of this fine organization now in its 122nd year of existence. Well aware of the responsibilities, I accept the challenges and pledge my best effort to carry out the duties and responsibilities of the office.

During the past year, it has been my privilege to attend most of the meetings of the four administrative councils and many meetings of the various commissions and committees of the Pennsylvania Medical Society. Although previously aware of the devoted and conscientious support of the physician council, committee and commission members in solving the problems of organized medicine, I cannot emphasize enough my admiration and respect for the tireless services of these 250-plus members of our Society. Furthermore, the highly efficient work of our administrative personnel is quite evident, and without their services the activities of our Society would grind to a conclusive halt.

The national government is continuing to become more involved in the health care of the citizens of our country, particularly in the financing of such care. The old adage, "He Who Pays the Piper Can Call The Tune" is applicable in this case, and the name of the tune is "The Cost, Availability and Quality of Medical Care."

Not only government but the citizens of the country are looking askance at the increasing cost of health care and are placing the responsibility for this, in a large degree, on the shoulders of the medical profession. Physicians' fees are a small part of the total cost of health care but are repeatedly overemphasized as a major factor by certain groups. While

physicians are not completely responsible for hospital costs, it is true that we are indirectly responsible for a large proportion of the cost as the group which controls admissions and discharges from hospitals, decides on the use of diagnostic and therapeutic measures, and to a certain extent the disposition of patients on leaving the hospital. As more complicated and sophisticated diagnostic and therapeutic procedures are introduced, involving the employment of more highly trained technicians, the cost will continue to rise. The continued and increasing function of utilization committees in hospitals can play an important part in controlling costs.

However, the utilization should not be limited to admission and discharge policies but should be slanted along disease entity lines regarding quality and cost of care. Our Council on Medical Service has performed magnificently in the utilization field and will have to continue to urge every hospital utilization committee to function adequately. The county medical societies have some responsibility in this field, namely—an active county utilization committee which should offer their cooperation with the hospital utilization committees in their area.

The extent to which the citizens and the Congress are willing and able to pay for health care will determine, to a large extent, the quality and comprehensiveness of this care. In all probability, within the next few years legislation will be passed providing national health insurance for all citizens. Whether this will be in the form of the American Medical Association *Medicredit*, one of the other plans introduced, or on a per capita basis, is uncertain. It will be influenced by

our ability to help control rising costs of health care.

We don't have much choice of the problems that are thrown in our lap, but we do have a choice as to how we will face and solve these problems. Let us consider some of them.

Manpower; Medical and Allied Health Personnel

It is generally recognized that our country faces a shortage of physicians, nurses and allied health personnel. The shortage of physicians has been estimated at from 50,000 to 70,000, and the statement has been made that we must graduate 18,000 to 20,000 doctors each year in comparison to the current 9,000 to 10,000 if we are to overcome the shortage in the next decade. It is doubted by many medical authorities that even this increase in new physicians will meet the needs of the country.

Just what part of the health manpower crisis results from the unequal distribution of physicians and what part is due to an inefficient system of delivering health services are debatable points.

The necessary increase in physicians only can be accomplished by the establishment of new medical schools or the increased enrollment of students in the existing schools. When it is realized that a ten-year period elapses between the initial planning of a medical school and the time the first physicians graduate from the school, it is recognized that this is a long-term program and will not meet our immediate needs. Moreover, the sixteen medical schools now in some degree of construction will not meet the need.

However, it seems possible that new medical schools could be established in a much shorter period of time if existing facilities were utilized better. There are many urban medical centers and clinics throughout the state which afford large out-patient facilities and hospital accommodations for several hundred patients. These centers have large staffs of certified specialists, some of whom already hold teaching positions in medical schools and universities. The cost and the time required to convert such facilities into new medical schools would be a fraction of the cost and time required in establishing new schools from scratch. It would seem possible for a university to have several medical schools under its administration as is being developed currently in Illinois and Texas.

In discussing increased enrollment with medical educators, the three factors mentioned as making this difficult are: inadequate facilities, inadequate supply of teaching personnel, and insufficient finances. If the lack of facilities is a major problem—and by facilities is meant buildings for basic sciences and hospitals for teaching beds and out-patient services—the many excellent liberal arts colleges, large and small, and the fine urban and community hospitals in the state should not be forgotten. It would seem to be quite possible for the colleges to develop and teach adequate courses in the basic medical sciences, particularly if a reasonable subsidy were granted, and if more community hospitals were affiliated with medical schools for teaching purposes. If a shortage of teaching personnel is the problem, the staffs of the community hospitals, many of whom are certified, are a source for part-time teaching positions in the medical schools. It is recommended that the Pennsylvania Medical Society encourage the medical schools to explore the increasing use of these two educational sources with the medical schools acting as the administrative centers and subcontracting courses among the colleges and hospitals at all levels of medical education.

However, it seems apparent that inadequate finances are

the biggest factor preventing the expansion of our medical schools. It is estimated that it costs about \$11,000 to \$12,000 per year to educate a medical student, with the average student able to pay only about \$3,000 per year. A large part of the balance must come from state and federal grants. In Pennsylvania, the three state-related schools receive about \$6,500 per student per year with the four non-related medical schools receiving from \$3,700 to \$3,900 per student. The proposed budget for 1970-71 provides the same amount per student for the three state-related schools and cuts in half the amount allocated per student in the non-related schools. Some of the operating costs have been met by federal grants made to certain faculty groups, largely for the purpose of research. The amount available from the federal government in the 1969-70 year was drastically reduced, and the prospects for the 1970-71 fiscal year are very poor.

If the medical schools are to meet the needs of the country in educating more physicians, government at the state and federal level must awaken to their responsibility in adequately financing the medical schools, preferably on a per capita basis, with assurance that this will be carried on year after year. Our Council on Education and Science and the Board of Trustees have approved the recommendation that the Pennsylvania Legislature grant to each of the seven medical schools \$6,500 per year per student and an incentive of an additional \$2,000 per year per student for increased enrollment. It is recommended that the Pennsylvania Medical Society take a more active part in soliciting the support of the members of the Pennsylvania Legislature for such a plan. This can only be accomplished if the individual county medical societies, through their membership, contact and impress on their local legislators the need for such action. The financing of new medical schools could be through a large bond issue by the state, and it is recommended that this program be proposed and actively supported by the State Society.

Medical Education

Medical schools, in terms of basic medical services and clinical medicine, are doing a fine job in preparing students for the future. They should be proud of their graduates in the field of the broad general specialist or the super-specialist. Unfortunately, neither the medical schools nor the insurance carriers have recognized or respected the fact that the big need of the country is for the primary physician—the family doctor. Medical education institutions are instrument of society and must be responsible to that society if they are to remain valuable. With the changes in curriculum over the past few years, the establishment of a core curriculum and the large amount of time available for elective subjects make it quite possible for a student to select elective subjects which, in the end, might have little relation to each other and might not prepare him for a specific specialty. It seems possible that certain basic courses could be developed for surgery, obstetrics and gynecology, internal medicine, etc., with a list of electives relative to each area. It would seem desirable to have an area for general medicine which would include medicine, pediatrics, psychiatry, preventive medicine, and possibly obstetrics. This could be under the supervision of a department of family practice and would provide a means for meeting the great need of the country for the primary physician. It is recommended that the Pennsylvania Medical Society continue to urge medical schools to take more definitive action toward educating the primary physician.

In the past, and probably rightfully so, medical schools

have devoted their entire attention to medical education. Now they are becoming involved in the delivery of health care and will be expected to train their students in a setting that is no longer centered on hospital experiences but on the conditions that will face the student when he enters practice. The non-technical aspects of health care, which are increasingly important today, are different in different settings and are increasingly important among patients who expect more than just technical competence from a physician. The students themselves are asking for: (1) more involvement in the communities, (2) better education in the socioeconomic fields, and (3) education in settings offering wider health service bases. It is recommended that the Pennsylvania Medical Society continue to urge the medical schools to produce physicians who are more relevant to societal needs of the citizens.

Continuing Education

As pointed out by William A. Sodeman, M.D., the rapid obsolescence of much of the physician's knowledge (the half life of the knowledge a physician utilizes is estimated at ten years) makes continuing education a necessity if the quality of medical care is to be maintained at a high level. Dr. Sodeman also pointed out the difficulty in planning a curriculum for physicians who range in ages from thirty to seventy years and who have had varying internships and residencies, have had various educational courses during their medical years, have attended varying numbers of medical meetings, and have spent different periods of time in reading medical literature. It is apparent that a profile of the individual physician would be of great help to the physician himself and to the physicians planning continuing educational programs. The American College of Physicians has sponsored a self-assessment examination for their members. These examinations not only point out the deficiencies of the participant but also are educational in the amount of work re-

quired of the participant in answering the questions. Numerous other specialty societies have sponsored similar examinations for their members. It is recommended that the Pennsylvania Medical Society, through its Council on Education and Science, urge the Pennsylvania Academy of General Practice to develop examinations for all members of the Pennsylvania Medical Society engaged in family medicine and to urge every specialty group organized in the Commonwealth to do likewise for their members. These examinations could be conducted so that there would be no public embarrassment to the participants.

At the present time there are many educational courses offered by medical schools, specialty groups, hospitals, large clinics, health and welfare groups, and last but not least, by our own Council on Education and Science. This has resulted in multiple programs in some areas, at times on similar subjects and at times drawing on the same group of physicians. There has also been a lack of coverage in certain parts of the state where such courses are needed. The Council on Education and Science has proposed a Pennsylvania Medical Continuing Education Institute organized with a board of directors composed of representatives from many of the state groups interested in medical education. It would be the responsibility of this group: (1) to undertake research that can give significant data regarding physicians' needs in continuing educational programs; (2) to develop programs where there are obvious defects and needs which cannot be met by other responsible groups; (3) to assist community hospitals in developing, planning and executing continuing medical educational programs; (4) to measure defects and evaluate results; and, (5) to secure funds to carry out the programs.

The Council has prepared a petition for charter and articles of incorporation, a set of proposed bylaws and a revised statement of purpose and it plans to submit them to representatives of interested groups at a meeting later this month. These steps taken by the Council have been in keeping with comments made by this House at the 1969



THE HOUSE OF DELEGATES hears opening statements of the president and president-elect.

session. It is recommended that the House reaffirm its approval of the direction taken by the Council and that it urge the Council to proceed with submitting a complete plan to the Board of Trustees and Councilors as soon as possible.

Continuing education has been on a voluntary basis by the individual physicians, and it is quite evident that some of our members have not taken advantage of the many courses offered. The American Medical Association, in an attempt to stimulate interest in educational programs, has established a Certificate of Recognition for those physicians who complete 150 hours of graduate education in three years in courses and ways approved by the AMA. The American Medical Association and the American Academy of General Practice are attempting to coordinate their activities so that courses approved by both groups will be recognized in meeting the requirements of their individual programs. Compulsory continuing medical education has been advocated by some for periodic relicensure by the state, membership in the county or state medical society or membership on a hospital staff. The Council on Education and Science submitted a recommendation to the Board of Trustees that membership in the county society and Pennsylvania Medical Society be conditioned on the completion of 150 approved hours of medical education in a three-year period. This was not approved by the Board of Trustees. It was advocated that any compulsory program for continuing education should involve all physicians licensed and practicing in the Commonwealth. At the present time there are several thousands of physicians practicing in the state who are not members of any county medical society or the state society and who, therefore, would not be covered by this program. It was also thought by the Board of Trustees that there was a great danger of a loss of membership in the Pennsylvania Medical Society, especially among our older physicians, if such a program was instituted. The only plan which would cover all the physicians in the state in requiring 150 hours of approved post-graduate education would be to make this mandatory for relicensure of physicians by the Pennsylvania Board of Medical Education and Licensure every three years. This has been vigorously opposed by many groups of physicians in the state.

However, if the Pennsylvania Medical Society is a learned society, one of its primary duties is to insure the competence and excellence of its members as practitioners of medicine. If we are an organization of technicians, government requires proof of competence. At the present time, continuing education and peer review are recognized as the two best methods of insuring the competence of our members and the quality of medical care. Organized medicine should recognize the necessity of some compulsory factors in this field and implement suitable programs if we do not wish non-medical groups to do it for us. It is recommended that the Council on Education and Science be commended for its activity in this field, and it is urged that the House of Delegates seriously consider its recommendations in continuing education.

Allied Health Personnel

The increased use of various allied health groups to assume certain duties now performed by physicians, thereby helping to relieve the physician shortage, has been proposed and implemented in the states of Washington and North Carolina. The use of ex-medical corpsmen in neighborhood clinics and the Medex Program in the state of Washington are the best known programs. It has been proposed to give registered,

nurses a short post-graduate program to enable them to qualify as physicians' assistants. Programs already have been established in colleges and universities in several states, and, undoubtedly, we will be faced with graduates from these courses seeking employment in Pennsylvania. The idea is good but it seems desirable that basic education requirements and courses be established by a national organization such as the American Medical Association and that graduates be certified by the AMA on completion of the course. This would be a basis for state licensing groups to certify or license such graduates so that they could be employed in the state. There are certain legislative measures which would be necessary for the employment of these groups in Pennsylvania. There also are certain pitfalls that must be guarded against such as the definition and limitation of legal duties of the assistant, method of compensation for services rendered under insurance programs, and liability insurance. We should be careful in developing the physicians' assistant group so that we are developing an assistant and not a *second-class physician*. The assistant should care for patients only with or under the supervision of a physician. We should not be a part to educating second class physicians and should never sacrifice quality for quantity. It is recommended that the Pennsylvania Medical Society cooperate with the State Board of Medical Education and Licensure in introducing necessary legislation to cover this allied health group.

Delivery of Health Care

One of the important problems in medicine is the necessity to devise a workable health system for all of our people and especially for those who, for whatever reason, fault or failure, have until now had to be satisfied with a partial compromise with reference to quality and available health care.

It seems apparent that no monolithic method for the delivery of health care, and possibly for its financing, can make sense in our pluralistic society. What may be feasible are numerous and diverse systems that interrelate multiple methods and varying approaches to a common goal of quality health care for all. Our goal cannot be obtained as in the case of the manufacture of an automobile where the components and details that will make the finished product are readily determined.

Certain groups strongly support the combination of prepayment plans with a multi-specialty group practice as offering the distinct possibility of bringing about a significant improvement in the health care delivery system through the more efficient use of available manpower and the expeditious use of the less costly forms of care. Several insurance companies are financing experiments along this line. More hard data are needed on group practice and its impact on quality of care, access, utilization of hospitals, and cost. Data are also needed on escalation and comparison of utilization of hospital facilities for different forms of medical practice, namely: solo practice on a fee-for-service basis, multi-specialty group practice on a fee-for-service basis, and on an enrollment prepaid basis.

It probably will be extremely difficult to get physicians to live and practice in socially and economically depressed areas in the cities unless there is marked improvement in the housing conditions, in education and cultural opportunities, in the economic level and in the elimination and control of crime. The establishment of neighborhood health clinics and health centers, staffed by medical schools in the medical centers and by community hospitals in the smaller cities, seems to be the logical solution. This should be done with the consultation and cooperation of all the local physicians

(Continued on Page 12.)



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REFERENCE COMMITTEES worked a full day October 6, with many members going back to committee work following the state dinner. Committee reports were heard and voted on by the House of Delegates at Wednesday's session. Shown above are shots of some committees in action as heated debate on a number of vital issues were heard.

New President Speaks

practicing in the area and with the approval of the county medical society. Temple University has two neighborhood health clinics in their third year of operation. They are helping to meet the needs of certain deprived areas in Philadelphia. It is understood that additional neighborhood health centers are being started by some of the other medical schools in Philadelphia and that the Philadelphia Department of Health is transforming some of their regional offices into health centers. It is recommended that the Pennsylvania Medical Society encourage and assist the smaller cities and towns in the state who have economically depressed areas to become active in this field and encourage the local county medical societies to take an active part in this endeavor.

In some of the rural areas of the state, the problem is somewhat different. Here there is a limited supply of physicians available to cover a large, sparsely settled area of farmlands and small communities. While the patient may be quite a few miles from the nearest physician, the availability of good roads and modern means of transportation make this much less of a problem than it was fifty years ago.

Under such circumstances the establishment of a centrally located clinic operated on a twenty-four hour basis by a group of local physicians might be the answer to the problem.

In Perry County, with a population of 23,000, seven physicians and no hospital, laboratory or x-ray facilities within its border, a corporation of 400 citizens led by four of the local physicians has been formed for the purpose of erecting a medical center with an adjacent nursing home of 100 beds at an estimated cost of \$2,000,000. Fifty acres of state-owned land will be sold to the corporation at a nominal sum when definite plans and commitments for financing have been negotiated. They have received a Certificate of Need for a nursing home from the Pennsylvania Department of Public Welfare and anticipate 90 per cent financing from government sources. At the present time, citizens of the county go to Lewistown, Carlisle and Harrisburg for laboratory work, x-ray examinations and hospitalization. It is estimated that \$25,000 in "seed money" for hiring archi-

(Continued on Page 33.)

Address Of William A. Barrett, M.D. To The PMS House Of Delegates



WILLIAM A. BARRETT, M.D.

Tempus fugit. This past year has flown more rapidly than any other I have known. Too rapidly because there has never been enough time to do the many things I wanted to see done. Yet, in one respect, the wheels turned so slowly that many projects have not been completed; some have not actually been started. Discussions on many problems are still taking place. This aspect of my term of service as your President has been frustrating.

But, on the brighter side, there are many experiences of this past year which have been personally satisfying and rewarding. For example, to have had the privilege—as a member of the Board of Trustees—of helping to make decisions and formulate the policies which guide our profession; to have attended many of the council and commission meetings and to have seen at first hand the sincerity and dedication with which our working committees tackle the everyday problems of medicine; to have visited various county medical societies to learn the problems, needs and attitudes of members in different areas of the state; to have visited the adjoining state medical societies as your representative and learn of their approach to our problems; and to have had the assistance of a very capable administrative staff on all occasions. These are very pleasant memories.

To this House of Delegates and to the Allegheny Delegation in particular, I shall always be grateful for giving me this opportunity to serve our profession.

Even before the time of Hippocrates (460 B.C.) the medical profession had been serving the people. Certainly since then, physicians have taught—to the students who wish to learn—the art and science of their day and the students, in turn, added the newer scientific advances to enrich the next generation. For more than 2,000 years, physicians have been recording their finest accomplishments and their newest discoveries in the medical record bank for use by others in the service of mankind.

Each of us, as students and as practicing physicians, has been withdrawing—at will and without restrictions— from

the constantly accumulating body of knowledge stored in the minds, the ideals, the traditions and the publications of the medical profession. We have been restricted only by the time we wish to spend and our capacity to assimilate. This is an unlimited resource to which we were given access the day we entered medical school.

The education and post graduate training we have received have been primarily from the knowledge and experience of other physicians. The teaching of students and other physicians has been traditionally considered a duty and a responsibility by our profession.

Although a few may become unscientific, self-sufficient, ungrateful or even pecuniarily motivated, each of us has a debt to his profession. Before Socrates drank the poison hemlock, he reminded his friend Crito to repay the debt of a cock he owed. Each of us, to the best of his ability, must contribute to that body of knowledge and to the maintenance of professional ideals.

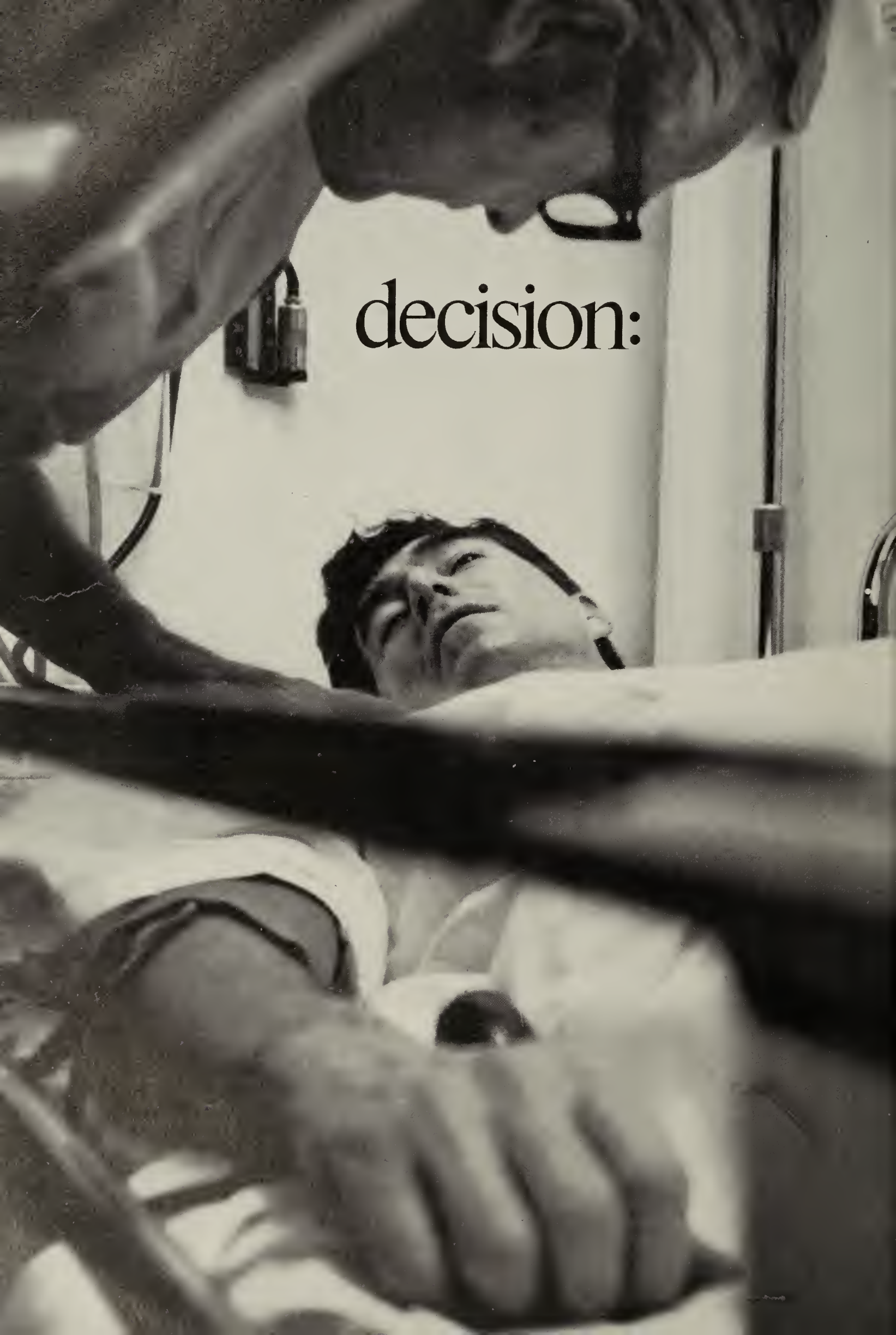
My debt to our profession can never be completely satisfied. However, you have provided me with this opportunity to repay a small portion of my indebtedness by serving as your President.

Structure and Services

Each of the four councils of the State Society is, in itself, a many faceted organization. The council members, members of subgroups and staff devote their time and energy to an unbelievable multitude of activities within their assigned spheres. To each, and its individual components, our Society is greatly indebted for consistent, dedicated services. For you—and for me—I thank them for an outstanding year, for assignments well done.

The activities of these councils and related components

(Continued on Page 71.)



decision:

Loridine[®] I.M.

Cephaloridine

1.5 to 3 Gm. daily
successfully treats many
moderately severe
infections*

- bactericidal action in vitro against susceptible organisms causing:
 - pneumonia
 - urinary tract infections
 - septicemia
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- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



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Loridine[®]
CEPHALORIDINE

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

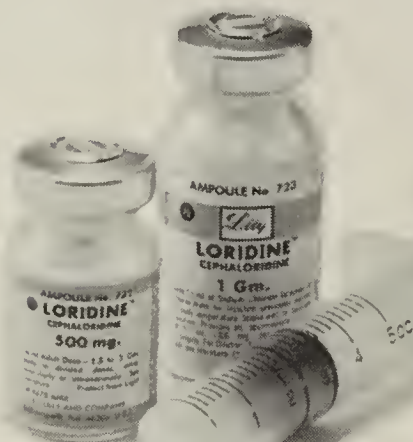
Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, par-

Loridine®

CEPHALORIDINE



**Usual adult dosage,
1.5 to 3 Gm. daily, is effective
against many moderately
severe infections due to
susceptible organisms.**

ticularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine

intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: Important—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms, and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered.

[082169]

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When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety,

and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in mid-evening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

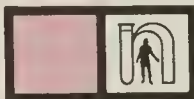


Painful night leg cramps...

unwelcome bedfellow for any patient—
including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Amlinophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Amlinophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

QuinammTM
(quinine sulfate 260 mg., amlinophylline 195 mg.)

Specific therapy for night leg cramps



Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® do an outstanding job of helping clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **SIDE EFFECTS:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening. **SUPPLIED:** Bottles of 100 and 500.

A-H-ROBINS

A. H. Robins Company
Richmond, Va. 23220

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

When an unnerving experience
compounds the pain



the compound analgesic
that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

Phenaphen[®] with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (1/4 gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2 1/2 gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming). **Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

A. H. Robins Company, Richmond, Va.

A-H-ROBINS

George P. Rosemond, M.D. President-Elect

George P. Rosemond, M.D. of Philadelphia, professor of surgery at Temple University School of Medicine, has been named president-elect of the Pennsylvania Medical Society at the Annual Session.

Dr. Rosemond will be elevated to head the organization in October of 1971, succeeding President William A. Limberger, M.D., of West Chester.

Dr. Rosemond has a wide background in medical affairs, including the presidency of the Philadelphia County Medical Society four years ago. The post of president-elect was one of a number of top offices filled as physician delegates—217 of them from all parts of the state—debated health and medical care questions.

Four vice presidents were elected. Charles K. Rose, Jr., M.D., Allentown, is first vice-president; Orlo G. McCoy, M.D., Canton, second vice-president; Charles A. Bikle, M.D., Chambersburg, third vice-president; and Edward T. Lis, M.D., York, fourth vice-president.

Raymond C. Grandon, M.D., Harrisburg was re-elected secretary. William Y. Rial, M.D., Swarthmore was re-elected speaker of the House of Delegates and the vice speaker, John B. Lovette, M.D., Johnstown, also was re-elected.

Three positions on the medical society's Board of Trustees were filled. Ralph K. Shields, M.D., of Bethlehem, and Cyrus B. Sleese, M.D., of Kittanning, were re-elected to five-year terms. William C. Ryan, M.D., Somerset, was named for the year remaining in the term of D. George Bloom, M.D., Johnstown, who resigned because of ill health.

Louise C. Gloeckner, M.D., Conshohocken, was elected to a five-year term on the Judicial Council.

Six delegates and six alternate delegates to the American Medical Association were elected. The delegates are Drs. William A. Barrett, of Pittsburgh, Park M. Horton of New Milford, Edmund L. Housel of Philadelphia, William A. Limberger of West Chester, William Y. Rial of Swarthmore and William B. West of Huntingdon. The alternates are Drs. R. William Alexander of Reading, Jerome Chamovitz of Sewickley, Leo C. Eddinger of Allentown, Raymond C. Grandon of Harrisburg, George A. Rowland of Millville, and R. Robert Tyson of Philadelphia.

Robert F. Beckley, M.D., Lock Haven was chosen alternate delegate



GEORGE P. ROSEMOND, M.D., Philadelphia, center, newly named president-elect of the Pennsylvania Medical Society, is flanked by President William A. Limberger, M.D., left, and William A. Barrett, M.D., immediate past president, immediately after his election at the 121st Annual Session of the PMS House of Delegates.

to the AMA to fill the term of John F. Hartmann, Jr., M.D., Erie, who resigned because he has taken a post at AMA headquarters in Chicago.

The delegates elected Fred C. Brady, M.D., Pittsburgh, as a member of the Committee to Nominate AMA Delegates.

Elected district censors were: Drs. James H. Allison of Gettysburg; Robert A. Schein of Pittsburgh; Arthur R. Wilson of Dayton; Herman Bush of Beaver; James K. Gordon of Bedford; Eugene Mendelsohn of Reading; John W. Hurst of Altoona; Willis W. Redding of Towanda; Stanley F. Peters of Plumsteadville; William R. Fitzsimmons of Butler; Warren F. White of Johnstown; James M. Steele of Tamaqua; H. Richard Ishler of State College; Grant W. Bamberger of Honeybrook; Theodore B. Koenig of Knox; Fred Pease of Clearfield; George J. Treires of Lock Haven; C. Paul Moser of Bloomsburg; David D. Kirkpatrick, Jr., of Meadville; Hans S. Roe of Carlisle; Hamblen C. Eaton of Harrisburg; Edward G. Torrance of Drexel Hill.

Also, Drs. James L. Hackett, Sr., of Emporium; Robert L. Loeb of Erie; Othello S. Kough of Uniontown; Albert W. Freeman of Shippensburg; William

W. Bartholomew of Waynesburg; Fred-eric H. Steele of Huntingdon; Samuel Cohen of Blairsville; Franklin S. Bizousky of Punxsutawney; John C. Sanner of Scranton; William A. Atlee of Lancaster; Gerald H. Weiner of New Castle; C. Ray Bell, Jr., of Lebanon; Frederick R. Bausch, Jr., of Allentown; Donald F. Closterman of Kingston, Wilfred W. Wilcox of Montoursville; Ralph E. Hockenberry of Kane; Robert W. Sass of Sharon; John R. Hunter, Jr., of Lewistown; Claus G. Jordan of East Stroudsburg.

Also, Drs. Rudolph K. Glocker of Pottstown; Isaac L. Messmore of Danville; Walter J. Filipek of Hellertown; J. Mostyn Davis, Jr., of Shamokin; Frank A. Belmont of New Bloomfield; Charles M. Thompson of Philadelphia; Herman C. Mosch of Coudersport; Joseph T. Marconis of Pottsville; Alexander Solosko of Myersdale; Raymond C. Davis of Susquehanna; James W. Montague of Blossburg; John S. Purnell, Sr., of Mifflinburg; George S. Smith of Franklin; Donald J. Furman of Warren; Herbert J. Levin of Donora; Howard R. Patton of Honesdale; Leslie S. Pierce of Greensburg; John S. Rinehimer, Jr., of Tunkhannock; and William C. Langston of York.

State Society Honors Eugene P. Pendergrass, M.D.

A seventy-fifth birthday cake and congratulations from President Richard M. Nixon and HEW Secretary Elliot Richardson added to the festivities as Eugene P. Pendergrass, M.D., Philadelphia, received the Distinguished Service Award of the Pennsylvania Medical Society as the highlight of a night of honors at the annual dinner-dance.

The message from the president and his cabinet member noted that the work of Dr. Pendergrass has been recognized throughout the world and said, "the American people are greatly indebted to you, Dr. Pendergrass, and I am happy to join with the Pennsylvania Medical Society in paying you the honor you so richly deserve."

Congressman Fred B. Rooney of Northampton County, a guest at the annual banquet, requested and received permission to have inserted in *The Congressional Record* the remarks of Dr. Pendergrass in response to receiving the award.

Dr. Pendergrass responded to receiving the award as follows:

Mr. President, Mr. President-Elect, Dr. Horton, Dr. Rial, Members of the Board of Trustees and Councilors, Members of the House of Delegates, Distinguished Guests, the Past Presidents of the Pennsylvania Medical Society, Friends, Ladies and Gentlemen:

This is a great moment in the lives of Betty and Gene Pendergrass—and I include all others—and there are many—responsible for the image or the symbol which is being honored tonight.

An occasion like this happens only once in a lifetime for this evening's recipient. Therefore I have given much thought to what will be said rather than hazard an extemporaneous statement.

Just imagine sitting at one's work on Thursday morning, March 12th; receiving a long distance telephone call from Dr. John Harris, who in a warm,

deliberate and dignified manner told me of the action of the Distinguished Service Award Committee and that of the members of the Board of Trustees and Councilors. That telephone call, Park Horton's telegram on the same day, and the official letter on Friday created a world that has assumed the parameters of a fantasy. Even in a dream one really cannot grasp the significance of such a distinguished award.

First, I wish to thank each member of the Distinguished Service Award Committee: Drs. John Harris, George E. Farrar, Jr. and J. Everett McClenahan; and the members of the Board of Trustees and Councilors; Drs. Park M. Horton, David S. Masland, A. Reynolds Crane, LeRoy A. Gehris, Ralph K. Shields, George A. Rowland, H. Thompson Dale, Robert S. Sanford, David J. Keck, Cyrus B. Sleese, William J. Kelly and D. George Bloom; and all the officers of the Pennsylvania Medical Society for the great honor they



EUGENE P. PENDERGRASS, M.D., Philadelphia, receives the PMS Distinguished Service Award from William A. Barrett, M.D., immediate past president, in the photo at left. At right, Dr. Pendergrass chats with fellow radiologist, John H. Harris, Sr., M.D., Harrisburg, PMS past president, who served as chairman of the Distinguished Service Award Committee.

have conferred on me. I humbly accept the Award and in so doing, I am happy to testify that you have honored achievements that only were possible because of a team program of associates, colleagues and friends in Pennsylvania and throughout the world and, a fabulous train of circumstances. I hope you will let me receive the Pennsylvania Distinguished Service Award as a kind of family tribute from all of you to all who have been involved in our program of service, teaching and investigation.

Secondly, I would like to introduce Betty Pendergrass. She, like a living spring, has supplied important elements of understanding and encouragement to her husband and to her children all of our lives. She shares in full measure any honor you bestow on me.

Thirdly, I want to thank all of my associates and staff and colleagues in the University of Pennsylvania. I have had the good fortune to surround myself with associates who were pre-eminent. In their search for knowledge they have pioneered observations that are basic to the understanding and the ongoing and rapid development of the discipline of Radiology. Such a combination of events tends to overwhelm my good friends. You have seen the result—an example of Einstein's Theory of Relativity— $E=Mc^2$. Together, we were able to develop a climate that attracted young men and women of superior talent. That has been good for each of us, for the university and hopefully for everyone in the communities in which they serve.

The staff includes physicians, radiobiologists, physicists, electronic engineers, nurses, technologists, business administrators, receptionists, secretaries, special aides, cleaning personnel, students and trainees in several categories. *Every individual's role is as important as each link is to a chain.* The staff, and all participants involved hundreds of people and over a half century of years. There was good team play even though there were wide differences of opinion. That was healthy and the expertise of one was complemented by that of another. We had no motto—but there was emphasis on mutual tolerance and individual excellence.

Isn't it most unusual that this great honor to our team occurs on my birthday, October 6, 1895, and this year is the seventy-fifth anniversary year of the discovery of x-rays by Wilhelm Konrad Roentgen, November 8, 1895?

It seems that to receive such a distinguished award, one has to live



DR. AND MRS. PENDERGRASS are shown above sharing the joy of having birthday congratulations played and sung as a special cake for the occasion is presented.

at the right time and be known by the right people.

One immediately thinks of people events that have played important roles in one's development.

The influence of my parents has been pre-eminent. Their devotion, leadership and hard work made it possible for me to obtain a college and medical education.

The requirements of World War I brought me under the continuing influence of Dr. Henry K. Pancoast, professor of radiology at the University of Pennsylvania; as a chief and teacher while serving as a Medical Officer in the U. S. Navy, and after the war as a member of his staff at the University of Pennsylvania. Dr. Pancoast also was responsible for initiating my participation in organized medicine. Our team program was one of hard work—service to our patients and colleagues, basic and clinical investigation and teaching. No one in medicine or any other discipline has had a better opportunity than I have had. My associates and those who have trained with us are superb and they have carried on in the United States and many foreign countries. Some of them are here tonight. I continue to learn from them and their contributions have made a major impact on any achievements that have been attributed to me.

I salute the many members in the Pennsylvania and Philadelphia Medical Societies with whom it has been my privilege to work. Those days of "decision concerning Workmen's Compensation, the Blue plans, state and federal funds for the indigent, tuberculosis control, infant and maternal mortality,

the delay period of appendicitis mortality and many others; provided a forum not unlike those of today which include Medicare, Medicaid, regional plans, mental illness, drug addiction, alcoholism and the environmental factors influencing the supply of natural resources and those threatening human health."*

It is not possible to scoop up all the stars in the heavens and thank them individually but there is Dr. Carl Lechner, medical editor of **PENNSYLVANIA MEDICINE** who has given me the privilege of serving with him in a minor capacity over the years. That experience is one that I treasure. With his devoted associates and his wife Delores, he excels in spite of all difficulties.

I also salute the executives and supporting staff of the Pennsylvania Medical Society. Over the years, that dedicated group of women and men have served in a selfless and superior way in order that organized medicine may continue to provide vigorous leadership in the total health field with the hope that: In a truly civilized world, progress will mean a social design in which the economic and technological effort will be focused on the creation of the environmental values best suited to the development of human potentialities.

Ladies and gentlemen—friends—our cup runneth over. Betty and I thank you with all our hearts.

*Dubos, Rene: *Life is an Endless Give-and-Take with Earth and all her Creatures.* Smithsonian 1:13-17: April 1970.

Mrs. Gehris New President Of Woman's Auxiliary

Over 300 delegates, alternates, guests and members of the Woman's Auxiliary to the Pennsylvania Medical Society gathered at the Host Farm Resort Motel, Lancaster, October 4-7, 1970 for their forty-sixth annual convention. The group was welcomed to Lancaster by the president of the Lancaster County Medical Society Woman's Auxiliary, Mrs. Henry W. Huffnagle, III. Convention Chairman Mrs. Henry S. Wentz and co-chairman Mrs. Joseph L. Eckenrode were presented at the opening session, and received the thanks of officers and delegates for their efforts.

The Auxiliary's House of Delegates voted to establish a State Auxiliary Health Careers Financial Aid Fund within the Educational and Scientific Trust of the Pennsylvania Medical Society. The fund will provide loans for

the training of all paramedical personnel.

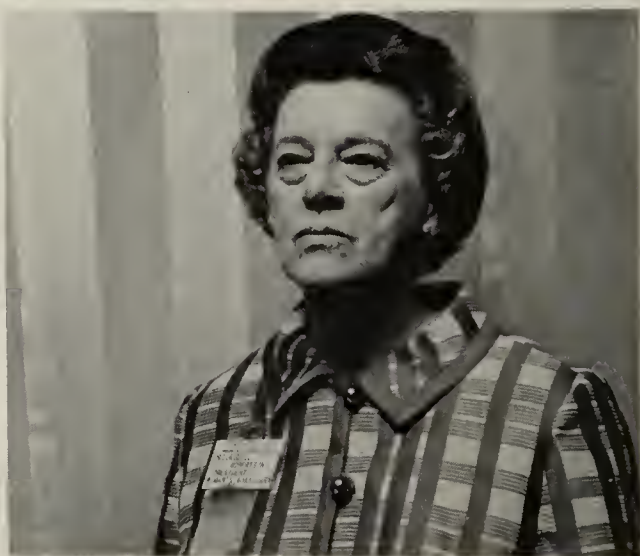
Awards were presented to the county societies which contributed the most on a per capita basis to various funds. Lawrence County took the honors for support to the AMA Education and Research Fund. The Mifflin-Juniata group gave the greatest amount per capita to the Educational Fund, and Greene County gave the greatest amount per capita to the Medical Benevolence Fund.

The Founder's Award, established to create a permanent honor for and reminder of exemplary leadership and to establish an award citing a physician's wife who does outstanding community service work and serves with distinction and who portrays ideals,

was presented for the second time. The award went to Mrs. Paul C. Craig, former state and national auxiliary president. She is an honorary member of the national auxiliary and of the Woman's Auxiliary to the Student American Medical Association. Mrs. Craig is also a distinguished daughter of Pennsylvania.

Honorary membership was conferred upon Mrs. Kermit L. Leitner who has given years of distinguished and faithful service, although she has not served as president of an auxiliary.

Mrs. Leroy Gehris of Reading succeeds Mrs. John Schneider of Pittsburgh as president. Mrs. Ralph Blasiolo of Monogahela was named president-elect to succeed to the presidency a year from now.



MRS. JOHN A. SCHNEIDER, top left photo, immediate past president of the Woman's Auxiliary to the Pennsylvania Medical Society presents the president's gavel to incoming president Mrs. Leroy A. Gehris, right. Mrs. Frank J. Corbett, speaker of the House of Delegates and chairman of the resolutions committee is shown in top photo, left, presenting an honorary membership resolution to Mrs. Kermit L. Leitner, right. In the bottom left photo, Mrs. W. Wayne Babcock, left, founder of the state auxiliary, Mrs. Axel K. Olson, center left, chairman of the Founder's Award committee and Mrs. John A. Schneider, right present the Founder's Award to Mrs. Paul C. Craig, center right. Mrs. R. C. L. Robertson, president of the Woman's Auxiliary to the AMA, is shown in the bottom right photo as she addresses the Woman's Auxiliary.

AP Chief Says 'We're Sorry' To Physicians

When a newspaperman admits to an error that's news! It happened last month, as the following letter from the chief of the Washington Bureau of the Associated Press, Marvin L. Arrowsmith, attests:

"We're sorry the lead of our story mentioned in yours of September 23 was misconstrued. The phrase, 'A survey of physicians has disclosed that nearly half...', was intended to mean half of those surveyed. And, as you noted in your letter, the subsequent paragraphs spelled out exactly what was intended in the lead.

"In hindsight, the phrasing certainly could have been more precise."

The letter came in response to a communication sent by the Pennsylvania Medical Society staff at the direction of then President William A. Barrett, M.D., Pittsburgh, which criticized the Associated Press for "sloppy" reporting in a news story about alleged deficits in Physician income tax returns.

The letter written in newsmen's language to Mr. Arrowsmith, follows:

I protest what I would class as a prime example of sloppy reporting out of your Bureau. At least I hope it was just sloppiness and not deliberately misleading.

I refer to an article moved for AM's of September 22, 1970, the lead of which read as follows: "Washington (AP)—A survey of physicians has disclosed that nearly half failed to report all funds received from Medicare and Medicaid programs on income tax returns, a Treasury Department official told a Senate panel yesterday."

If the story is read carefully, one discovers in the seventh paragraph that not half of all physicians have failed to report funds but that half of a group of physicians and dentists suspected of failing to report all income in fact may have failed to file accurate returns. The list of 1,500 cited by Whitaker was from an original pre-selected group of 11,000 physicians and dentists who received \$25,000 or more from Medicare and Medicaid in 1968. The actual 13 per cent of the selected group of physicians and dentists who had "substantial deficits in their reporting" is a far cry from the "nearly half" described in your lead.

If one gains the impression from your lead that half of all physicians in the nation fail to report all funds received, and such has been the over-

whelming impression from a quick survey that I conducted, the lead would have been accurate had it said that three-tenths of 1 per cent of the physicians and dentists in the nation have failed to report all funds received...

Please do not misunderstand. Any false income tax reporting is too much. As a medical society, we will even help in any way that we can to root out and punish any of our members who have deliberately cheated on an income tax return. My objection is to the carelessness in reporting that creates false impressions.

I would suggest that had the article carried the following lead, it would have been a much more accurate reflection of the facts: "Nearly half of a group of physicians and dentists

suspected of failing to report as income all of their Medicare and Medicaid receipts had 'substantial deficits' in their tax returns, a Treasury Department official told a Senate panel yesterday..."

After your article appeared in papers throughout Pennsylvania, I did a random telephone and local on-the-street survey and failed to find a single person who had read all or part of the story who did not have the impression that it said that half of all physicians had cheated on their income tax returns.

Most of the heads from the Pennsylvania newspapers that I have seen attest to a discernment on the part of the head writer that was not evident in the lead that your Bureau filed.

Nutrition Experts To Appear In State

The AMA council on foods and nutrition and the Pennsylvania Medical Society have joined forces in formulating a program in medical sciences to be presented in colleges and universities throughout the state during the 1970-1971 academic year. The purpose of the lecture program is to inform students and faculty of recent developments in medicine and stimulate interest in the medical sciences.

Denis Abelson, M.D., director of the Clinical Research Center and associate professor of medicine at the University of Pennsylvania will speak on "Research and Discovery in Medical Science" at Gannon College in Erie, November 9; Allegheny College in Meadville, November 11; Slippery Rock State College in Slippery Rock, November 12; and at Bloomsburg State College in Bloomsburg on February 9.

Lewis Barnes, M.D., chief of service of the department of pediatrics at the University of Pennsylvania School of Medicine spoke on "Nutrition and Brain Development." This lecture was given at Lafayette College in Easton and at Juniata College in Huntingdon, and can be heard at Muhlenburg in Allentown, February 9, 1971.

"Malnutrition as the Result of Plenty" will be the topic presented by Donald Berkowitz, M.D., associate professor of medicine at Temple University Medical School. His lecture was given at Clarion State College in Clarion, October 20; and Westminster College in New Wilmington, October

21. They can be heard at Lehigh University in Bethlehem on March 3 and at Albright College in Reading on March 4, 1971.

Jerome Knittle, M.D., associate professor in the department of pediatrics at Mt. Sinai School of Medicine in New York, delivered a lecture on "Early Factors in Cellular Growth and Development." Bucknell University in Lewisburg, October 20. He will repeat it at Pennsylvania State University in University Park, November 12; St. Francis College in Loretto, November 18; and Indiana University of Pennsylvania in Indiana, November 19.

Robert McGandy, M.D., associate professor in the department of nutrition at Harvard University School of Public Health in Boston, will speak on "Environmental Factors in Chronic Disease and Aging." He will deliver his lecture at King's College in Wilkes Barre, December 15; and at East Stroudsburg State College in East Stroudsburg, December 16.

Physicians On Air

The Allegheny County Medical Society and the Pittsburgh Academy of Medicine are cooperating in presenting a half-hour health information radio show on station WTAE every Sunday starting at 9:30 p.m. Each program features a physician moderator interviewing physician guests on matters of medical interest to the public.

SVRMP Makes Changes In Advisory Group

A number of changes have been made on the Regional Advisory Group of the Susquehanna Valley Regional Medical Program (SVRMP) as the result of recent action.

Raymond C. Grandon, M.D., Harrisburg, PMS secretary, was re-elected from the eleven-county Southern Area Committee.

Theodore R. Baranik, administrator of Memorial Hospital of Bedford County, Everett, and Margaret A. Greiner, R.N., director of nursing, Altoona Hospital, will represent the Appalachian Highland Area Committee as a result of re-election to three year terms.

George W. Rinck, II, M.D., Middle-

burg, and Lorraine Visneski, R.N., Bloomsburg, were elected to three-year terms by the Northeastern Area Committee.

Charles L. Youngman, M.D., Williamsport, and Aaron H. Claster, Lock Haven, will represent the Northern Area Committee for the next three years.

Irvin K. Uhler, D.D.S., York, was elected by the Southern Area Committee to fill the unexpired term of Robert A. Kumpf, formerly of Lewisburg.

Appointed by their respective health organizations and institutions were: John H. Harris, Jr. M.D., Carlisle,

Pennsylvania Division, American Cancer Society; George T. Harrell, M.D., Hershey, Pennsylvania State University College of Medicine and Hershey Medical Center; John R. Clark, D.D.S., Harrisburg, Pennsylvania Department of Health and John H. Harris, Sr. M.D., Harrisburg, Pennsylvania Medical Society.

The Regional Advisory Group provides guidance and advice in the planning and operation of SVRMP, and reviews requests for funds to support regional and local projects.

Child Abuse Meet Set For Hershey

A one-day institute on "The Abused Child: A Community Responsibility" will be held Thursday, November 12, 1970, under the sponsorship of the Pennsylvania Departments of Health and Public Welfare and a number of interested groups, at Founder's Hall, Milton Hershey School, Hershey.

Guest speakers will include Vincent De Francis, J.D., director of the children's division of the American Humane Association; Vincent J. Fontana, M.D., director of pediatrics, St. Vincent's Hospital and Medical Center of New York and chairman of the city's Task Force on Child Abuse and Neglect; Marx S. Leopold and Mrs. Mary T. Denman, attorneys recognized for their work in formulating laws pertaining to child protection; and Miss Elizabeth Elmer, assistant professor of social work at the University of Pittsburgh.

Heart Association Chooses President

Charles A. Laubach, Jr., M.D., Danville, was installed as president of the Pennsylvania Heart Association during the Twenty-First Annual Assembly in Philadelphia. He succeeds E. Wayne Martz, M.D., of Kennett Square, who received the distinguished service medallion for outstanding leadership.

Dr. Laubach is chief of the cardiovascular and pulmonary disease section and of the laboratories at the Geisinger Medical Center. He is a past president of the North Central Heart Association, of the Montour County Tuberculosis Society and the Montour County Medical Society, and has been active in the Pennsylvania Heart Association for more than a decade.

Byberry Rehabilitates Retardates

It has been more than two years since Daniel Blain, M.D., director of the Pennsylvania State Hospital (PSH) at Byberry, selected 250 retardates from the hospital to be placed under the care of Maurice Linden, M.D., clinical director of the PSH Jefferson Unit.

Today 125 of the selected 250 are living in the community and are employed in industry or with the Philadelphia Association for Retarded Children workshops. Ninety per cent of these people have remained out of the hospital for at least a year compared to the usual rate of return (60 per cent) over that same period at the general hospital. Of those remaining in the hospital the average age is 47 and the average length of stay is 20.05 years. For patients with potential to leave, emphasis is placed on returning to the community, however not all patients will be able to leave. Those remaining under the care of the unit have music therapy, movement therapy and learn of personal hygiene to make their life

in the hospital as easy as possible.

Dr. Linden credits the great success of the retardate program to the highly trained staff in psychiatry, psychology and nursing. Emphasis is placed on the needs of the whole person, not just educational needs he stated. Dr. Linden also said that at the hospital the patient finds acceptance, warmth and new goals for living rather than rejection. In the last three years the Jefferson unit has decreased its population from 603 to 425.

AAGP Congress Votes Name Change

The nation's second largest medical group has voted to change its name of twenty-three years. The American Academy of General Practice, now will become known as the American Academy of Family Physicians.

The action, which will take a year to develop fully, was taken by the Academy's Congress of Delegates in the final session of the group's annual meeting in San Francisco. It immediately preceded election of J. Jerome Wildgen, M.D., Kalispell, Mont., as president-elect. William E. Lotterhos, M.D., Jackson, Miss., became president of the group, assuming the role relinquished by Edward J. Kowalewski, M.D., of Akron, Pa.

According to Mac F. Cahal, executive director, the change of the name was an important step in the continuing move to revitalize the nation's primary health care forces.

Mr. Rineman On HUP Board

John F. Rineman, executive director of the Pennsylvania Medical Society, has been elected to the Board of Directors of the Hospital Utilization Project (HUP).

The announcement of the action, which took place at the annual meeting of the Hospital Utilization Project, was made by HUP Associate Director William H. Schofield. Pittsburgh-based, HUP is organized to serve the entire state.

Robert C. Eyerly, M.D., a Danville surgeon, has been re-elected to represent Pennsylvania in the American Cancer Society's National House of Delegates. Dr. Eyerly will serve as one of two medical professionals representing the state's 100,000 cancer volunteers.

Jack Myers, M. D., has been appointed a university professor at the University of Pittsburgh School of Medicine. As a university professor Dr. Myers will devote his full-time efforts to research, teaching and patient care. Dr. Myers, an internationally recognized authority in medical education, is well known for his research contributions in problems of the circulatory system and disease of the liver. At the present time Dr. Myers is chairman of the American Board of Internal Medicine and vice chairman of the National Board of Medical Examiners.



DR. ESCARO



DR. DEE

Cecilio C. Dee, M.D., and Daniel Escaro, M.D., recently completed their pathology residencies at York Hospital. Both have received certification as diplomates by the American Board of Pathology. Dr. Escaro has now joined the hospital staff and while Dr. Dee plans to return to Manila.

George K. Tokuhata, M.D., director of the Division of Research and Biostatistics, Pennsylvania Department of Health, was one of seven panelists in a symposium sponsored by the National Cancer Institute on virus-related cancers at the third annual meeting of the Society for Epidemiological Research at the University of Minnesota. Dr. Tokuhata has been involved in cancer research for the past twelve years. At the symposium he discussed factors related to the incidence of cancers among families and the con-

nection of breast feeding in childhood cancers.

Marie Valdes-Dapena, M.D., received a \$20,000 grant from the Institute of Child Health and Human Development of the National Institutes of Health for a two year study of sudden and unexpected death in infants. Dr. Dapena, a member of the department of pathology at St. Christopher's Hospital for Children in Philadelphia, has been assisted by Nirmal Basavanand, M.D., a resident in pediatric cardiology at the hospital.

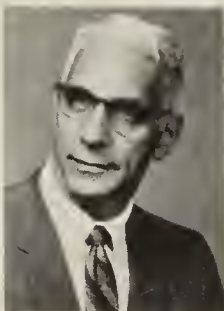
Michael M. Geduldig, M.D., has been named assistant professor and director of the Division of Gastroenterology of Hahnemann Medical College and Hospital, Philadelphia. Dr. Geduldig was formerly the chief of gastroenterology at Harrisburg Polyclinic Hospital.

The Pennsylvania Allergy Association elected its 1970-1971 officers at its recent annual meeting. They are President Macy I. Levine, M.D., Pittsburgh; President-Elect Martin A. Mureek, M.D. of Greensburg; Secretary Gilbert A. Friday, M.D., Pittsburgh and Treasurer Charles Woodcock, M.D., of Harrisburg.

David Minard, M.D., chairman of the Department of Occupation Health at the University of Pittsburgh Graduate School of Public Health has been designated director of the Commission on Environmental Health by the Armed Forces Epidemiological Board. The Commission investigates environmental hazards affecting military personnel and the more than half million civilian employees of the Department of Defense.

Eight Philadelphia area physicians have been accepted to membership on the staff of Friends Hospital. Those accepted are Kenneth Kron, M. D., Leo Madow, M.D., Edward Teitelman, M.D., Sami Michael, M. D., Zeno Paclisano, M.D., B. Perry Ottenberg, M.D., Ahmet Ulus, M.D., and Theodore J. Wasserman, M.D. Each of the physicians was nominated by a staff psychiatrist at Friends.

Bernard Behrend, M.D., an expert in occupational medicine, has been named director of Employee Health Service at Albert Einstein Medical Center's Northern Division. As director of Employee Health Service he will oversee the health care of the full-and-part-time staff at the hospital. He will continue to serve as associate professor of occupational medicine at the Medical College of Pennsylvania.



DR. BEHREND



DR. GAMBESCIA

Joseph M. Gambescia, M.D., clinical professor of medicine at Hahnemann, was named teaching coordinator for the department of medicine at the new Saint Agnes Hospital. Currently Dr. Gambescia is director of the department of medicine and is a co-chairman of the hospital's development committee.

Norman Kendall, M.D., professor of pediatrics at Temple University School of Medicine has received a \$111,000 federal grant to provide improved care to high-risk pregnant women and sick infants. It is the first such grant awarded by the bureau in the middle atlantic and New England states.

The acting dean of Temple University School of Medicine, William P. Barba II, M.D., has been appointed the director of the North Philadelphia Regional Health Affiliates.

George W. Schemm, M.D., Philadelphia, a neurosurgeon specializing in research in cerebral vascular disease, was appointed professor in the neurosurgery division of the Medical College of Pennsylvania. Dr. Schemm has also had several papers on cerebral aneurysms published.

D. Ernest Witt, M.D., Bloomsburg, was recently nominated to serve as Columbia County coroner. Dr. Witt has been practicing in Bloomsburg for more than twenty years.

Dues

Utopia seems very close, to some Americans, and nearly all of us have drifted into a vague belief that every problem can ultimately be eliminated to the satisfaction of everybody. The favorite method is to form a committee and relax while awaiting the results. If that seems insufficient, a government grant is viewed as an almost infallible way to cure all ills.

A much-discussed problem is medical society dues and it is a troublesome one. This is not the time for the regular dues editorial and this is not that recurrent blight on medical writing. This writing intends to be more philosophical and makes no immediate demands. I hope it may be less dreary than the annual plea for prompt pay.

A calm and philosophical attitude toward medical society dues is almost non-existent. Studies conducted by eavesdropping on the deliberations of the pundits in the staff room reveal a strong and asymmetrical polarization. Many voices say that the dues are far too high, that they are not well spent and that organized medicine is no damn good. Some say that the money may be expended on programs which are actually harmful to us practitioners.

A few feeble voices, from workers in the fields of organized medicine, say that the dues ought to be raised in order to improve our performance. They mention the need of spending more money for such projects as graduate medical education, scientific programs, relationships with our fellow citizens and, most commonly, improved political action.

But there is a small group of physicians who do study this problem dispassionately. They are the members of the finance committees who are responsible for seeing that the money carries out the increasingly numerous and increasingly expensive projects in which we are engaged. I suspect that these physicians dream of standing before the membership and announcing: "This year the dues will be x dollars lower than in 1969." But it is a dream—the dues are unlikely to be lowered.

And yet, the doctor is actually confronted with a real problem when his dues statement appears on his desk. The

size of our medical association dues is not inconsiderable and the doctor's expenses are all rising. The dues bill comes at a time when other bills are troublesome; dues of other organizations, second semester tuition, Christmas bills and the like.

So we vociferously take the position that the dues are unjustifiably high and that those medical politicians are careless, inept, disorganized or worse.

But, I can vouch for the care and consideration which is given to the spending of the members' dues dollar. I can show any member who really wants to pursue this study of dues how hard and unattractive is the work of the finance committees at all levels.

I submit that the practitioner's solution to the dues problems should begin with a careful and realistic review of the entire picture. Medical officials, elected and staff, should be held to their duties and these should include a careful and constant appraisal of the programs of our associations. The need for a society project, its relative value in the total program and the possibility of economy in carrying it out should be weighed and should be constantly surveyed. Overlaps should be prevented. Methods of accomplishing our objectives by the least expensive methods must be studied. Coalition and joint action with other groups should be attempted in order to get the best results from the expenditure of our resources.

But it seems inevitable that such a thoughtful reviewer will also come to the conclusion that dues must inevitably be kept near their present level or higher, that they are not likely to be reduced significantly without impairing the efficiency of the medical societies and that they are not going to be eliminated in the future.

Having accepted the inevitability of medical society dues as one accepts the certainty of death and taxes, one can go back to the staff room and continue the discussion—after having dutifully paid the dues.

CBL

Guest Editorial

Commitment And Due Process

The Mental Health Act of 1966 for the Commonwealth of Pennsylvania has now been in effect for more than a year. The concept of *due process* is one that many psychiatrists have pondered frequently this year.

We have seen our communities struggle as they attempt to identify the persons to be empowered to initiate commitment proceedings. We have seen our frightened, confused, perhaps incompetent, patients in courtrooms attempting to tell judges why they do not see the need for psychiatric help, and then have had to "testify against" our own patients. Court and lawyers' fees add an unnecessary financial burden to the family and the community.

Many of us wonder how this constitutes progress. But it appears that due process must be served if this situation is to be changed. This means taking time to convince legis-

lators and judges that the training required to obtain a medical license is better preparation for deciding who needs psychiatric hospitalization than is training in jurisprudence. What looks good on paper, or sounds good in theory, in this case has developed into a regressive, time-consuming, and expensive method of getting a patient to a physician. Frequently this has led to long delays in obtaining treatment and made a patient more inaccessible and alienated.

We have been in data-collecting stages and have accumulated many examples of harm and delay produced by this procedure. Now is the time to press for reworking or clarifying the act.

A. H. Hostetter, M.D., Editor
Pennsylvania Psychiatry

PENNSYLVANIA MEDICINE

Getting Into Medical School

GEORGE A. ROWLAND, M.D.
Millville

Recently, a colleague with a son in high school asked my advice on preparing him for medicine. Specifically, he wanted to know how to get his boy into medical school. It made me stop and think.

In the past, the path to medicine was pretty straightforward. If the boy was not a doctor's son he often became a doctor's protege. At one time that actually meant holding the doctor's horse. Later, the boy learned to roll pills and mix medicines. He watched the doctor set fractures, suture wounds, and comfort the bereaved. By the time he made a career decision, he knew whether he wanted to be a doctor or not. If he got sick at the sight of blood or if he could not relate to human suffering he turned in another direction. If he had the aptitude, a recommendation from his mentor all but assured his admittance to medical studies.

That was a most inexact way to find the best physicians. It did seem to supply doctors who were motivated to care for people. Today, our method is much more precise although it develops hardly any of "the kind of doctors who will do you any good," as my uncle used to say.

How do they pick medical students? A friend of mine told me of his son, a straight "A" student right through college. He was accepted by every top-grade medical school he applied to—at once, on a simple transcript without recommendation or interview. The schools were anxious to

get him. They did not know whether he was possessed of the milk of human kindness or whether he was a kleptomaniac, a paranoid, or sex pervert.

It is only the border-line cases who are interviewed, those relatively retarded kids who have high "B" averages. A good word from a teacher or a friend might help here. A history of experience as a hospital orderly might be favorably regarded but only if the academic level is otherwise equal. That is always the deciding factor.

So, the answer to the question—Don't take the boy out on calls or get him a hospital job in summer. Send him to prep school and get him special courses in how to study and the art to taking examinations. Let him know that grades are important in themselves. They are much more important than how they are obtained. The boy may turn out to be a twisted human being, but this seems to be the highway to an MD degree these days.

We should not be surprised that such a system turns out scientists instead of humanitarians. Maybe the difficulty is all a matter of semantics. Perhaps, we should change the title from "Medical School" to "Research Institute of Medical Science." Such a place would not be troubled by kids who want to see patients. We could then start new institutions which would be called "Training Schools for Practicing Physicians."

Be A Party Leader

Physicians and their wives will be infinitely more effective in politics through the holding of party office rather than through election to public office. Party leadership is not difficult to attain. Both parties are undermanned and always have been. If you prove you're serious, prepared to work, and willing to play the game according to the established rules, you can rise quickly, for both parties want men and women with intelligence, training, and influence within the community. Physicians and their wives will find the welcome mat on the doorstep.

To underline this point, surveys have shown in recent years that only about 1 to 10 voters actually works at politics by going to meetings, working for a party, or giving money to a campaign. Only about 2 per cent belong to any sort of political organization. And only about a fourth of the American public say that they are likely to talk about political matters—even casually—with other people.

How can physicians and their wives help fill the partial vacuum created by the apathy of so many Americans, and, in the process, make their influence felt quickly and strongly?

1. Register and vote religiously in the primaries.
2. Join either political party as soon as possible.
3. Study your state's election laws, and your party's regulations.
4. Develop a voice in the nominating process so that your party chooses candidates better representative of your thinking.

5. Work as a member of your candidate committee.
6. Provide generous financial support to good candidates—and your party, too.
7. Become involved in your local Political Action Committee.



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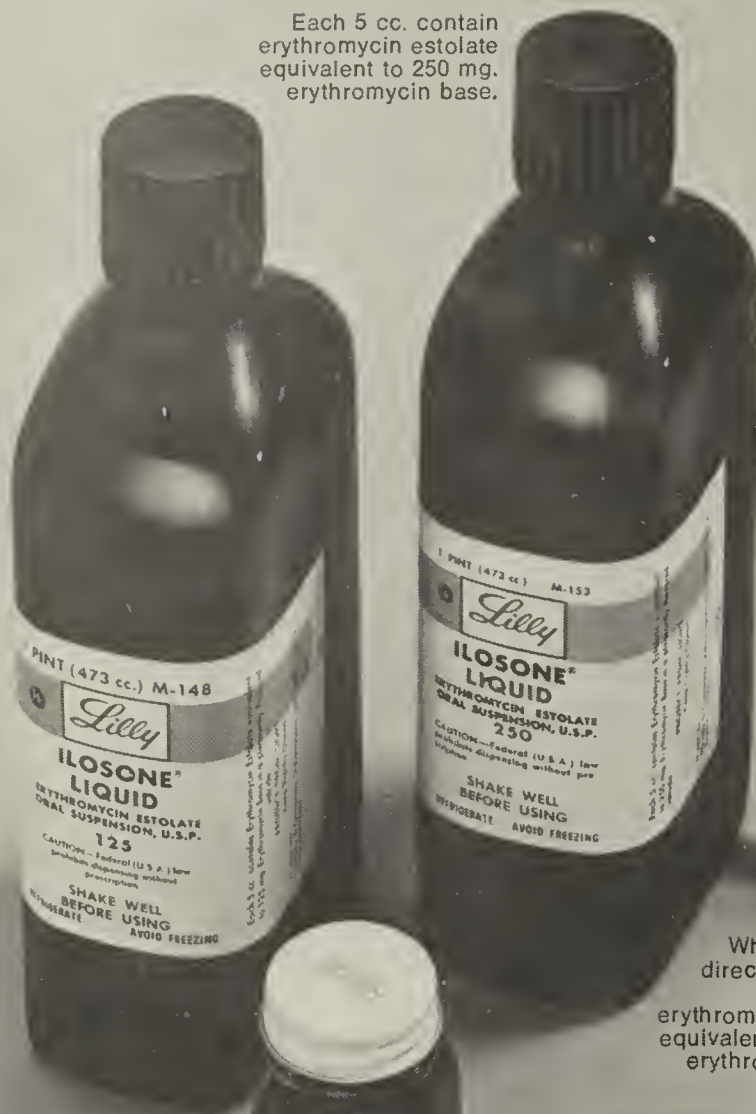
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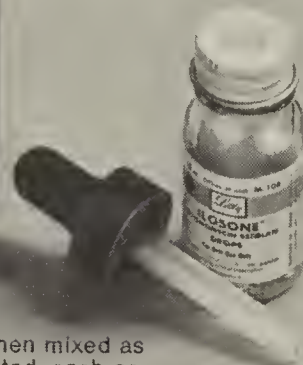
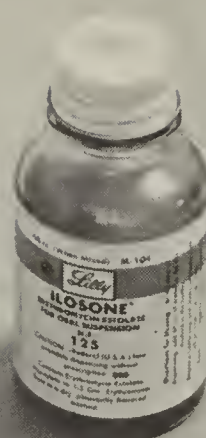
fully. If bronchospasm progresses, this medication should be immediately discontinued. **Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied:** Mucomyst-10 (acetylcysteine), a sterile 10% solution, in vials of 10 ml. and 30 ml.; Mucomyst (acetylcysteine), a sterile 20% solution, in vials of 10 ml. and 30 ml.

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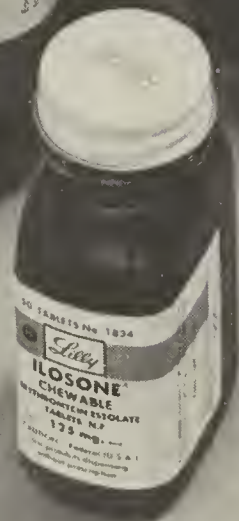


When mixed as directed,
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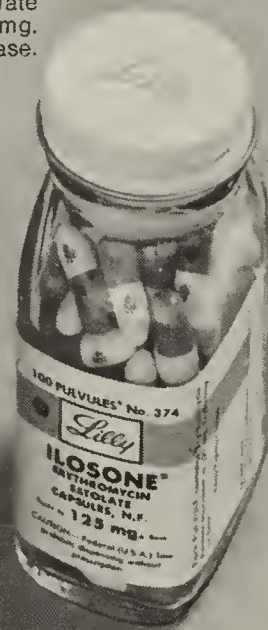


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equivalent to 100 mg.
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New President Speaks

pects and other planning aspects is needed to start the project.

This seems to present an unusual opportunity to evaluate this proposed method of the delivery of health care in a sparsely settled area. The furnishing of a comprehensive health care plan on a prepayment basis might be feasible. Blue Shield and Blue Cross have displayed interest in total coverage and might be willing to participate in such a program in this one county as a pilot project. The degree of comprehensive care would depend on the desire and financial ability of the citizens to pay for such a plan. The development of a fully comprehensive health care program should place special emphasis on preventive care with the use of paramedical personnel and an effective home care program. Services of specialists might be made available a certain number of days a month by visits of physicians from neighboring medical centers, and hospitalization would have to be arranged with the hospitals in the three adjacent counties now serving the area.

Such a program demands a thorough study in addition to the amount of work already done by the corporation. Such a study should initially start with a detailed survey of the citizens of the county, particularly as to their desire and financial ability to participate in the program, their present medical care coverage, the opinion of industries now giving their employees medical care coverage, and many other factors. It is recommended that the Pennsylvania Medical Society offer its good services to the West Perry Clinic Corporation to help in conducting such a survey and if, at the conclusion of this study, the program is deemed feasible, to help in securing the "seed money" necessary to start the program in operation.

Peer Review

Peer review is a subject that has been receiving considerable attention by government and by organized medicine. Government is concerned not only about the cost of health care but also about the quality of health care. The Fulton-Broyhill Bill introduced in the House of Representatives in late July providing tax credits for the purchase of voluntary health insurance, also calls for the creation of a peer review organization in each state, county or other political subdivision for the purpose of establishing a formal system of review of utilization, charges and quality of health services.

The term "peer review", which means review by a person who has equal standing with another individual, is not new to organized medicine. Peer review is the basis of county medical society grievance committees, county society boards of censors, district councilor review committees, state judicial councils and many other committees of organized medicine. The present emphasis on peer review committees is the control of utilization, charges, and quality of health care.

Peer review is the basis in the functioning of hospital utilization committees which are responsible for the proper utilization of hospital facilities from the standpoint of admission, length of stay and discharges and also for the quality of care rendered the patients. Many utilization committees are establishing standards for quality care from a disease-oriented standpoint. The control of cost should also be a function of the utilization committee in the evaluation of diagnostic studies ordered for the patient. It is probably true that, in so-called teaching hospitals where the intern and resident staffs

are given more or less carte blanche in ordering routine studies, consultations and extensive x-rays, some patients are really over-studied, adding considerably to the cost of hospital care. Peer review of the cost and quality of care rendered by a physician in his office, extended care facilities, and in the home is now being advocated by certain government agencies.

Organized medicine must provide a method for determining acceptable ranges in fees for specific medical treatments, proper utilization patterns and the maintenance of quality medical care if government and third party insurers are to be prevented from entering this area.

It is apparent that a single plan for peer review of an individual doctor's practice will not be applicable for the country as a whole, and it seems advisable that such plans should be established on a county medical society basis. What may be workable in one county may not be in another, just from the standpoint of density and distribution of population and physicians.

The Nassau County Medical Society of New York has organized a peer review committee whose responsibilities are the following: (1) fees [cost control]; (2) utilization relating to overperformance of services or fraudulent reporting of services [cost control]; (3) utilization relating to admission and length of stay in hospitals, extended care facilities and nursing homes [cost control]; (4) quality of hospital care; (5) quality of outpatient care; (6) availability of care. The county peer review committee acts primarily as an advisory committee to the hospital review committees regarding utilization and quality care in hospitals. Complaints regarding quality and cost of outpatient care are received largely from consumers, carriers, government agencies and other physicians, and each case is considered on its own merit. If patterns of poor quality of office or other outpatient care are developed, additional investigative procedures are employed.

Since peer review of outpatient services will, in all probability, be required in the not-too-distant future, it seems appropriate that organized medicine should take a positive approach to this problem. It is recommended that each county medical society establish a peer review committee and formulate plans for implementing this program in their individual county. It is also recommended that the Council on Medical Service and the Council on Education and Science jointly prepare guidelines for peer review activity at a county level and distribute them to the individual county medical societies.

Communications

One of the continuing problems of the Pennsylvania Medical Society is satisfactory communications with our component county societies, with individual members and with the citizens of our Commonwealth. Despite the use of all the means of communication now available, the administrative staff principally responsible for this field of endeavor will tell you that the results in many instances are very discouraging. There is a story of a cemetery in a particularly bleak portion of a large city. Adjoining the multitude of up-thrust gray stones was a row of three telephone booths erected in that spot for reasons unknown. Were they placed there for the midnight convenience of the dead or for mid-day visitors who might attempt to speak with the silent people beyond the fence? I suspect that the wires did not run in the proper direction to accomplish either purpose, and there was something disconnected and disjointed about the whole endeavor. It reminds me of some of our attempts at the state level to communicate with some of our county medical societies and some of our members. It is probably

symbolic of an aspect of our world, a world that—however strung with connecting threads—is endowed with an open-ended and perverse quality we shall never completely master.

It is said that the best relations of the medical society with the public is the direct relationship between the individual physician and his patient. Possibly the communications and relations between the State Society and the membership can be improved by personal visits by officers of the Society to the county medical societies. In the spring of this year, a letter was addressed to all of the county medical societies expressing the willingness of the President-Elect to attend a meeting of the county medical society for the purpose of presenting the various programs and the problems of the State Society, a desire to hear the opinions of the individual members on these programs, and any commission or omission of activities of the State Society. The response to this letter has been most gratifying, and invitations have been received to attend meetings from May on. To date we have visited nine county medical societies and two councilor district meetings and have fifteen scheduled invitations for the balance of this year and the early part of next year. It is hoped that these will be beneficial to the membership, and we are sure they will be helpful to the State Society officers.

A very important effort in improving communications between the Pennsylvania Medical Society and its members is the recent formation of the Interspecialty Committee, first advocated by George E. Farrar, Jr., M.D., during his term as President of the Pennsylvania Medical Society. For too long a period the Pennsylvania Medical Society and the specialty societies have been fragmented in many of our fields of endeavor, and it was in the hope of making available to the officers, Board of Trustees, and House of Delegates the knowledge, wisdom, facilities and energies of the medical specialty societies in Pennsylvania that this committee was formed. It will also facilitate access of medical specialists to the policy making of the Pennsylvania Medical Society and should help to improve coordination of professional effort in the state. The first meeting of this committee was held on June 3, 1970 at the headquarters building at Lemoyne, and State Society officers attended it in addition to the specialty representatives. It was a most interesting and rewarding meeting, and such meetings should help to improve the relationship and mutual understanding between the specialty groups and the State Society. Four meetings each year are planned with an annual report to be submitted to the House of Delegates.

Unsatisfactory communications not only exist between the Pennsylvania Medical Society and its members but also between the Society and the citizens of the Commonwealth.

There have been many conferences and meetings on a regional, state and national level called by state and national officers and organizations for the purpose of discussing the problems of health care in our country. The two main questions concerning such meetings are these: (1) do we, as the deliverers of medical care, listen to these groups but fail to hear what they are saying? and, (2) do these groups really represent and relate what the average citizen of the country wants in health care?

In an effort to communicate better with the citizens of the Commonwealth, again at the suggestion of Dr. Farrar, a Citizens' Advisory Committee of seven members was appointed by the Board of Trustees. It is anticipated that this committee will advise and assist the Society in evaluating the social and economic aspects of health care in the Commonwealth and will submit specific recommendations to the Board of Trustees for appropriate action. The first meeting

was held July 9 at the Pennsylvania Medical Society Headquarters and was attended by the members of the committee, officers of the Society and the executive assistants of the four Society Councils. It was entirely an informative meeting for the benefit of members of the committee. A second meeting is planned for the fall. It is quite evident that the members of the Advisory Committee now have a far better idea of the programs and functions of the Pennsylvania Medical Society and their advice and recommendations may be extremely helpful in solving our problems.

The fourth area in which improved communications are desirable is with the students in our seven state medical schools. Definite improvements have been achieved by providing the president of each Student American Medical Association Chapter in Pennsylvania with a seat in the House of Delegates, including the right to vote, serve on reference committees and introduce resolutions. The invitation to members of the SAMA Chapters to attend specific meetings of the Board of Trustees and various meetings of our councils and commission is also helpful. Unfortunately, the attendance of SAMA representatives at these various meetings has not been as good as might be hoped. Also, SAMA does not represent all the students of the medical schools; the percentage of membership is from a low of 23 per cent to a high of 100 per cent. Numerous methods have been employed in the past to improve communications without too much success, and this problem will continue to need the attention of our Council on Public Service.

Litigation and Insurance for Medical Liability

Over the past five years the protection of the physician against litigation for alleged malpractice has been one of the foremost problems of the medical society. With the marked increase in the number of cases entered in the local courts and the large awards made in some cases to the plaintiffs, providing the physician with adequate insurance has been the paramount issue. Conditions resulted in many insurance companies threatening to withdraw from the field in Pennsylvania particularly if marked increases in premium rates were not approved by the Insurance Commissioner. In 1969 the Pennsylvania Medical Society attempted to establish a group malpractice insurance program, and sixteen insurance companies were asked to submit proposals. While two companies initially displayed some interest, not one of the sixteen submitted a proposal. In the last few months two companies again showed some interest. At this year's annual meeting of the American Medical Association held in June, the Board of Trustees announced that progress was being made in the development of a professional liability insurance program for members of the association. The proposed program is intended to provide long-term protection to members of the Association in those states in which the state medical associations elect to accept the provisions of the program and agree to become joint sponsors. It is not intended to compete with existing liability insurance programs which are currently sponsored by state medical associations or component county societies. It is rumored that this will be started as a pilot program in several states and that Pennsylvania has been named as one of the state medical societies to be asked to sponsor this program.

There are serious questions about a group sponsored program at the state or national level. Undoubtedly it would decrease competition and reduce the number of companies willing to offer coverage in the state. For a group program to be successfully started, it is quite possible that premiums initially will be lower than that of companies currently

operating in the state and that many poor risks will be insured. If the group carrier becomes disenchanted and withdraws, as has occurred in some states, physicians will be faced with a real dilemma in securing coverage.

Lately the number of new suits filed in Pennsylvania seems to be leveling off, although awards granted by juries are still increasing. The Pennsylvania Medical Society does not have complete information about all the suits filed in the state, usually only being informed of suits by physicians who do not have any insurance coverage or by county medical societies when they become involved. In the first seven months of this year, no new cases were reported to the Society.

However, adequate insurance coverage—while vitally necessary—is not the complete answer to solving the problem of professional liability. Medical-legal pretrial panels have been advocated by some and have actually been used in certain parts of the state. In the past some insurance companies have been very much opposed to such panels and have advised their policyholders not to become involved in such proceedings. The decisions are not binding and are believed by insurance companies to be strongly biased in favor of plaintiffs' lawyers.

Our Commission on Forensic Medicine has held several meetings with members of the Pennsylvania Bar Association to discuss the compensation paid to lawyers in malpractice cases and has advocated discontinuance of fees paid on a contingency basis. It is believed by some that if this method of compensation were discontinued, the number of alleged malpractice cases would decrease considerably. As of this date, no progress has been made in these discussions.

Medical malpractice arbitration boards lately have been under serious discussion, and the California Hospital Association with the California Medical Association is planning a pilot program of arbitration for ten of its member hospitals. The American Arbitration Association has had extensive experience in the areas of labor disputes, workmen's compensation and commercial disputes but limited experience in the handling of medical malpractice cases. Arbitration does appear to offer some advantages over court procedures as a method for the settlement of disputes. The advantages are: (1) a saving of time, (2) a saving in expenses, (3) a means for settling disputes with greater privacy, (4) elimination of a trial by jury which theoretically minimizes the element of sentiment which so often makes the verdict of a jury unpredictable, (5) the proceedings permit greater flexibility than can be provided in court, and (6) the availability of a prompt decision encourages early settlement of a claim.

It is not clear whether the benefits outlined would afford a practical solution to the key problems of medical liability insurance, namely, its availability and its rapidly increasing premiums. It is not known whether arbitration would decrease the frequency or the amount of compensation awards.

Here again the findings are not binding in most states. A few states have passed legislation making decisions binding. This seems worthy of further investigation, and it is recommended that the Council on Medical Service and the Council on Governmental Relations continue to explore the feasibility of the utilization of arbitration panels as the solution to this problem.

PaMPAC

With the rapid expansion of activities of the state and federal government in the area of health care, physicians have a vested interest in helping government solve the problems and meet the medical needs of the citizens of this country. Since most government programs are the result of legislation, it is

our responsibility to support and elect officials who will vote for medical legislation that is in the best interest of the citizens of the country. In the last year, over 160 bills were introduced in the Pennsylvania State Legislature and about 1,600 bills in the U.S. Congress dealing with some phase of health care.

To accomplish this goal, we must adequately support PaMPAC which is devoted to supporting candidates who acknowledge and favor medicine's legislative goals. This support by PaMPAC is not dependent on the candidate's party affiliation but on his philosophy concerning medicine. PaMPAC also carries on a definite program in political education as evidenced in the political action workshops it has held in the past three years.

In 1970, PaMPAC was involved in supporting twenty-five candidates in the primary election. Of these candidates, twenty-one will be running for election in November—a batting average of .840.

The success of PaMPAC depends on two factors—an active and devoted political action committee and an adequate supply of funds. The first we have, and in addition, we have an increasing number of physicians and their wives who are playing vital roles at the grass roots levels, giving of their time and talents for the election of their candidates.

Additional money is urgently needed. In 1969, PaMPAC was third in total contributions received in comparison with the other state PAC's in the country but did not rank in the first ten in the ratio of members to potential or in dollars contributed per physician.

The best way to raise money from the membership of the Pennsylvania Medical Society is to have AmPAC-PaMPAC dues included in the total of the annual billing sent out by county medical societies to their members. This results in about 50 per cent of the members of the Pennsylvania Medical Society contributing to PaMPAC. If the AmPAC-PaMPAC dues are listed on the bill as a separate item and not included in the total amount due, only 15 per cent of the Pennsylvania Medical Society members make contributions. At the present time, there are six county medical societies that do not include PaMPAC membership in their billings.

It is recommended that the six county medical societies seriously consider including PaMPAC membership dues in their billings and that all county medical societies include AmPAC-PaMPAC dues as one item in the total amount billed.

In approaching an elected official for support or opposition to a legislative program of importance to medicine, your opinion will have much greater weight if you have supported him in other non-medical legislation and particularly if PaMPAC has financially supported him in his campaign. Remember that 89 per cent of your PaMPAC contributive dollar is used for candidate support. Let's get on the ball!

These are some of the problems confronting the Pennsylvania Medical Society which I regard as most important. There are other problems, some of which you may feel are as important as the ones mentioned.

We must look to the future in the solution of these problems, not forgetting the past and the history of the Pennsylvania Medical Society during its 122 years of existence. In closing, I quote from Dr. Martin Marty in his most recent book, *The Search for a Useable Future*: "Men act, in large measure, in the light of the future which they envision or project. But the raw material for their actions comes from remembered ideas, words, events, images and models. Thus their search for a useable future in any era will be grounded in their view of particular pasts".

(A list of source material for the information contained in Dr. Limberger's address is available upon request.)

Therapy Of Hypertension

PETER SIGMANN, M.D.

and

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Philadelphia

MORE THAN TEN YEARS have passed since the introduction of the first effective antihypertensive drugs: the Rauwolfia alkaloids and ganglionic blocking agents in the early 1950's and chlorothiazide in 1958. Other, more potent agents with fewer and less severe side effects were developed during the subsequent years, and much experience has been gained throughout the world in the use of these drugs. Simultaneously the surgical therapy of secondary hypertension was perfected. This time span appears sufficient to permit evaluation of therapy on the basis of the consolidated experience.

The rationale of therapy is based on the natural history of the disorder, which unfortunately is not always predictable. In treating patients with mild and inconstant elevation of the diastolic blood pressure, the aim of therapy is to prevent fixed hypertension. Once hypertension is established and fixed, the major objective is the prevention of vascular complications and ischemic damage, especially in the cerebral, renal and coronary arterial systems. In these often asymptomatic stages of hypertension, therapy can be regarded as one of the maneuvers of preventive medicine, whereas in accelerated or malignant hypertension, immediate and effective treatment is essential to short-term survival. Although the approach to treatment and intensity of treatment may differ according to the severity and duration of the hypertensive process, as will be explained, the desired goal is a sustained

normalization of the blood pressure with the diastolic pressure remaining below 95 mm. of mercury.

Before embarking on a course of therapy it is important to evaluate the etiologic and complicating factors in each case of hypertension. The purpose of a thorough evaluation is to identify surgically curable conditions and to recognize situations in which special therapy is required in addition to antihypertensive drugs. This can be done by means of a detailed history and physical examination followed by a basic series of laboratory tests. The studies should include urine analysis, blood urea and creatinine, serum electrolytes, electrocardiogram, roentgenogram of the chest, and timed intravenous pyelogram. Depending on what these studies reveal, additional specific studies are often necessary as a more or less routine procedure in evaluating very young patients or older persons with recent onset of hypertension, patients with evident vascular disease or deteriorating renal function, and those who are found to have hypokalemia, as well as patients with the clinical picture of Cushing's syndrome or pheochromocytoma. In all these groups of patients the diagnosis of essential hypertension must be confirmed by exclusion of known causes that can be cured surgically or by any therapeutic means other than the use of antihypertensive drugs. A family history of hypertension is not sufficient reason for assuming that a patient has "essential" hypertension.

Special considerations are required in the evaluation of patients who are found to have a low serum concentration of potassium, either spontaneously or after short-term use of thiazide

diuretics. In the absence of primary renal or intestinal potassium loss, these patients may be suspected of having primary or secondary hyperaldosteronism. Aldosterone-producing adenomas are known to cause hypertension, usually mild, whereas secondary aldosteronism is a feature in the pathogenesis of renal parenchymal or vascular hypertension. In these latter instances aldosterone is liberated from the adrenal glands by means of the renin-angiotensin mechanism, following renal ischemia. The process occurs in severe or "malignant" essential hypertension when vasospasm results in ischemia of the juxtaglomerular apparatus with subsequent release of renin, activation of angiotensin and liberation of aldosterone. It is usually easy to differentiate secondary from primary hyperaldosteronism on the basis of indirect evidence—for example, known stenosis of the renal artery. The definite diagnosis of primary aldosteronism requires the conclusive finding of high aldosterone excretion with sodium loading, i.e. under conditions conducive to aldosterone suppression, and low plasma renin activity in a state of sodium depletion, i.e. despite conditions that would ordinarily stimulate renin production. Secondary aldosteronism is distinguished by an increase in the serum renin activity, a finding that indicates a probable renal artery obstruction, which can be localized by means of selective renal vein catheterization.

The response to antihypertensive drug therapy is another factor to be considered in the decision for or against a major diagnostic work-up. Although the ideal way to treat secondary hypertension is to detect and remove the cause, some diagnostic studies (such as arteriography) are associated with significant morbidity. It may therefore be preferable to defer such studies if a patient with suspected secondary hypertension responds well to a medical regimen so that the blood pressure can be easily controlled with drugs. Conversely, special studies are rarely justified when a careful evaluation of the history, physical examination and basic series of tests indicates that the patient probably has essential (primary) hypertension. Occasionally, however, the failure of severe hypertension to respond to medical treatment after a fair trial of various regimens may raise the suspicion that a possible remediable cause of the hypertension has escaped detection. In these cases more detailed study should be undertaken even though the chance of

The effect of stress is shown in Figure 1. This diagram indicates the interrelation of the endocrine system and the sympathetic nervous system in hypertension. For example, stimulation of the sympathetic nervous system causes constriction of the arterioles and simultaneously stimulates the adrenal medulla. The consequent release of catecholamines can produce hypothalamic stimulation, which in turn stimulates the adrenal cortex. Adrenal cortical substances affect the neurotransmission of impulses and influence the concentration of electrolytes in the blood vessel. Simultaneously, renal vasoconstriction causes the release of renin, thereby activating angiotensin, and this results in the secretion of aldosterone. That hormone alters the renal excretion of electrolytes and leads to sodium retention. The higher concentration of sodium, in turn, also affects the blood vessels and the vasoconstrictive mechanism.

These observations indicate that it is therapeutically important to prevent stress whenever possible. Sedative medications may often be required in addition to drugs that interfere in the involved endocrine and metabolic pathways or act at the blood vessels.

SALT

The effect of sodium on blood pressure is well known. The blood pressure is directly related to the amount of exchangeable sodium in the body (Figure 2) and is probably related specifically to the concentration of sodium in the wall of the arterioles. The thiazide diuretics not only reduce the blood volume, but also decrease the total body sodium and thus reduce the blood pressure by decreasing peripheral vascular resistance. In addition, they appear to lower the blood pressure by a second, unrelated mechanism. This is especially suggested by the action of a related compound, *diazoxide*, which is devoid of diuretic properties but is a very potent hypotensive agent. The most significant disadvantage of the thiazides is loss of potassium that they cause simultaneously with the loss of sodium, thus requiring the addition of potassium salts or aldosterone antagonists. It appears that a reduction of the Na/K gradient at the tissue level is most important if vascular reactivity and thereby the blood pressure are to be reduced. This, of course, calls for the preservation of a normal concentration of potassium when sodium is reduced.

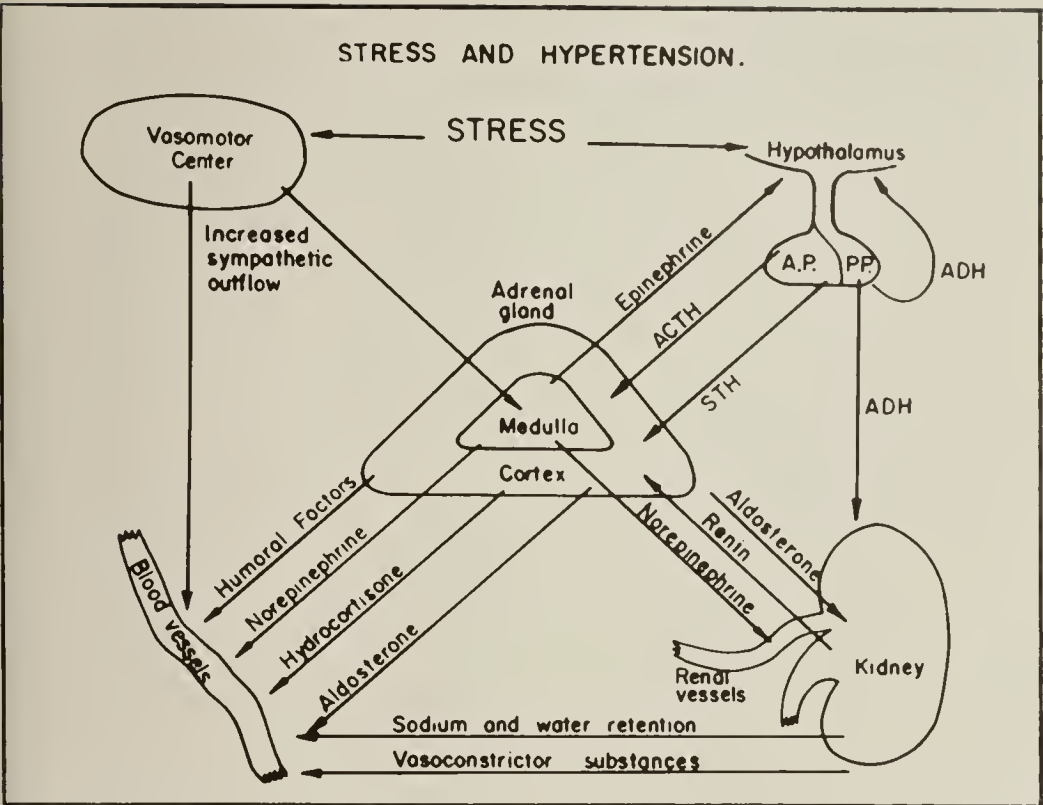


FIG. 1: Diagram showing the various pathways through which the effects of stress act to produce vasoconstriction and raise the blood pressure. (Reprinted through courtesy of W. B. Saunders Co., from "Hypertension", edited by J. H. Moyer, 1959.)

finding such a cause may be very slight.

ENDOCRINE CAUSES

No significant new developments have occurred in the surgical treatment of pheochromocytoma, aldosteronoma and Cushing's syndrome. The combined use of arteriography and retroperitoneal gas contrast radiography appears to be most helpful in locating adrenal tumors and hyperplasias. In cases of malignant pheochromocytoma with metastases the blood pressure has been controlled medically with phenoxybenzamine (Dibenzylamine®, Smith, Kline & French).

RENAL AND RENAL ARTERIAL HYPERTENSION

In *nephritis* specific therapy must be used in addition to antihypertensive therapy: namely, steroids and anti-metabolites in lupus nephritis and antibiotics in pyelonephritis.

In *unilateral* renal parenchymal disease the decision for nephrectomy is usually rewarded by a good result, if the diseased kidney had no significant function. In many cases arteriography and selective renal function studies are necessary for preoperative evaluation. In these patients with one shrunken kidney it is most important to rule out vascular obstruction of the remaining kidney. The increased flow to the hypertrophied kidney may conceivably predispose to arteriosclerotic lesions, and vascular surgery may be indicated

early to preserve function in the remaining kidney.

The diagnosis of *renal vascular* (arterial) hypertension is made by timed pyelogram and radioactive renogram. If necessary it is confirmed and quantitated by selective renal function studies or renin assays. Renal arteriography is necessary to locate the site and evaluate the extent of the arterial obstructive disease. The diagnosis of renal artery obstruction does not necessarily call for surgical correction. Vascular surgery is likely to be curative if there is localized unilateral or bilateral extrarenal obstruction, but not if the lesions are multicentric or intrarenal. Arterial surgery is indicated if it is necessary to protect renal function or if the blood pressure cannot be easily maintained at normal levels with medical therapy, including the use of spironolactone. Nephrectomy should be limited to patients with severe ischemic damage and contraction of renal mass on the affected side with compensatory hypertrophy on the contralateral side.

Dr. Sigmann is a senior instructor in medicine at Hahnemann Medical College and Hospital and Dr. Moyer is professor of Medicine and chairman of the department of medicine at Hahnemann.

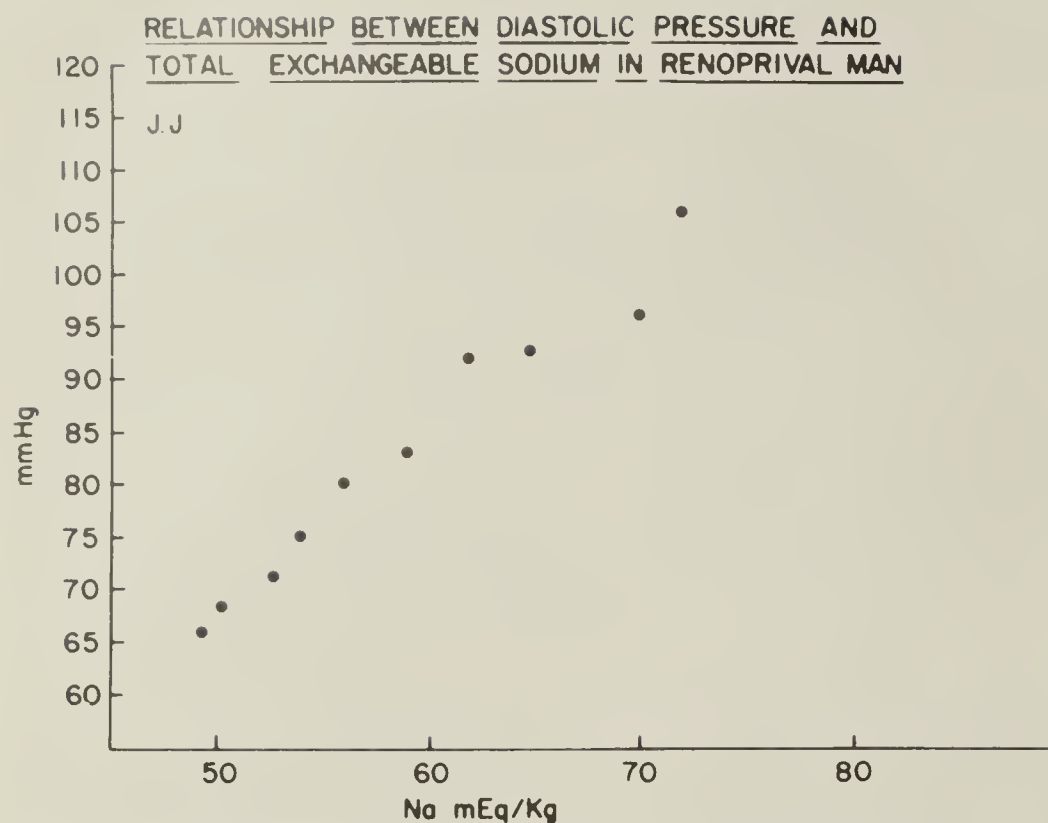


FIG. 2: The relation between diastolic pressure and total exchangeable body sodium in a patient whose kidneys have been removed. Following dialysis, when the amount of sodium is very low, the diastolic pressure falls to hypotensive levels. As sodium is increasingly retained, the diastolic pressure rises first to normotensive and then to hypertensive levels. (From Onesti, G., Swartz, C., Ramirez, O. and Brest, A. N.: Bilateral nephrectomy for control of hypertension in uremia. *Trans. Am. Soc. for Artificial Internal Organs* 14:364, 1968.)

Hydralazine (Apresoline®, Ciba) also exerts its effect directly on the smooth muscle cells of the arterioles and does not affect the autonomic nervous system. It has minimal orthostatic effect and tends to produce a relative increase in renal perfusion. The effects of hydralazine are of short duration, and the drug must therefore be given every six hours, in doses gradually rising from 10 mg. to a maximum of 100 mg. With prolonged administration, especially in high dosage, it frequently induces a syndrome indistinguishable from systemic lupus erythematosus. Therefore smaller doses are usually used, in combination with other agents. Hydralazine is a reliable agent for emergency therapy since it can be given intramuscularly or by intravenous drip. However, the side effects of headache, tachycardia, dyspnea, and drug sensitivity are serious deterrents to its regular use.

Sympathetic depressant drugs interrupt the sympathetic innervation of the blood vessels at various points (Figure 3). The more potent drugs are those that depress the sympathetic nervous system at the periphery, either at the ganglia or at the neuroeffector site where norepinephrine is released to cause vasoconstriction directly.

Drugs that block the action of norepinephrine either by blockade of synthesis or by depletion are most frequently used to reduce hypertension. Rauwolfia alkaloids, guanethidine (Ismelin®, Ciba) and methyldopa (Aldomet®, Merck, Sharp & Dohme) are the most commonly used compounds that act at this anatomic site. Although these drugs have other sites of action, it seems fairly well established that at the neuroeffector site they inhibit the synthesis of norepinephrine or bind it in such a way that it cannot stimulate the blood vessel to constrict. As a result, they reduce the blood pressure by depressing sympathetic activity.

Reserpine and the related Rauwolfia alkaloids are relatively mild antihypertensive agents if used orally (0.25 to 1.0 mg. daily), but when given parenterally reserpine is effective in hypertensive emergencies (initial dose 2.5 mg. followed by doses increasing by 2.5 mg. increments every two hours if necessary). The drug has a prominent sedative effect which may be an added therapeutic advantage. Peptic ulceration is one notable complication of the use of this drug.

Guanethidine (Ismelin®) acts like reserpine by depleting the neuroeffector

sites of norepinephrine, and both drugs are long-acting. However, guanethidine is much more potent and causes orthostatic hypotension in therapeutic doses. After a starting dose of 10 to 20 mg., increases in dosage for the ambulatory patient should not be made more often than at weekly intervals.

Methyldopa (Aldomet®) is a methylated analog of a norepinephrine precursor. It is thought not only to inhibit formation of the neurotransmitter by competitive action, but also to act as an antagonist to norepinephrine. Its effects are of shorter duration than those of reserpine or guanethidine, and it causes very little orthostatic hypotension. Methyldopa is therefore somewhat easier to manage than these other agents. The daily dosage of 500 mg. to 2 Gm. is divided into doses of 250 to 500 mg. to be taken two to four times a day, depending on the patient's response. It is especially useful in treating patients with diminished glomerular filtration rate, because it relieves renal vasoconstriction to an even greater degree than the vasoconstriction elsewhere in the total arterial system. This drug is also very useful in hypertensive emergencies, if given intravenously. In high doses, especially when given parenterally, methyldopa has a significant sedative effect. The major adverse effect of this drug is the development of red cell antibodies that occurs with prolonged use. Frank hemolytic anemia is, however, extremely uncommon.

Pargyline (Eutonyl®, Abbott) also blocks the sympathetic effects in the postganglionic segment. This drug is a monoamine oxidase inhibitor, and therefore its use results in a large accumulation of catecholamines at the sympathetic nerve endings. It inhibits not only the breakdown of norepinephrine but also its release. A potential danger exists when a patient on pargyline is exposed to substances that release catecholamines—especially tyramine (present in aged cheese), but also various commonly used drugs, including several antihypertensive agents. The drug has an especially prolonged duration of action (about two weeks) and causes orthostatic hypotension. It should not be used in combination with other drugs, except diuretics.

Ganglionic blocking agents inhibit the effect of acetylcholine at both the parasympathetic and the sympathetic ganglia. Accordingly they can never be used without causing side effects and are to be reserved for treating hypertension that is refractory to any

one or a combination of the previously described agents. Their effect on blood pressure is pronouncedly orthostatic and requires that patients abstain from resting in a completely supine position. Venous return and cardiac output are severely reduced, so that these agents are contraindicated in conditions with hypoperfusion of a vital organ. *Mecamylamine* (Inversine®, Merck, Sharp & Dohme) is the only drug in this group with a predictable effect when taken orally. *Pentolinium* (Ansolsen®, Wyeth) is an effective emergency drug, if given intramuscularly, whereas *trimethaphan camphorsulfonate* (Arfonad®, Roche) has an instantaneous and transient effect requiring well monitored administration by intravenous drip.

Combinations of various hypotensive agents are routinely used in all but the mildest cases of hypertension. Usually a thiazide diuretic is the basis of the therapeutic program, allowing marked reduction in the required dosage of the more potent agents and thereby reducing the side effects of therapy (Figure 4).

MANAGEMENT OF COMPLICATIONS OF HYPERTENSION

When deciding on treatment to reduce elevated blood pressure in a patient with evidently *insufficient blood supply to brain, heart or kidneys*, we may be guided by our knowledge of its effects on the vascular system. Hypertension causes constriction of the arterioles throughout the body, including those that control the collateral circulation bypassing an arterial obstruction. In such cases the blood pressure must be reduced with extreme care, gradually and slowly. Treatment includes regulation of the patient's body position, depending on the drug and the blood pressure. Here, too, the distant therapeutic aim is reduction of the blood pressure to normal. The period during which this goal is to be reached may vary from several days to several months, depending on the severity and duration of the disorder, as well as the extent of vascular disease. Periodic estimation of renal function may serve as a rational guideline.

If the patient has *renal insufficiency*, one must realize that sodium deprivation and forced constriction of blood volume will result in greatly depressed renal function, even exceeding the effect of the reduced perfusion pressure. Therefore supplemental sodium may be indicated for selected patients, if the blood pressure can be controlled by means other than those intended

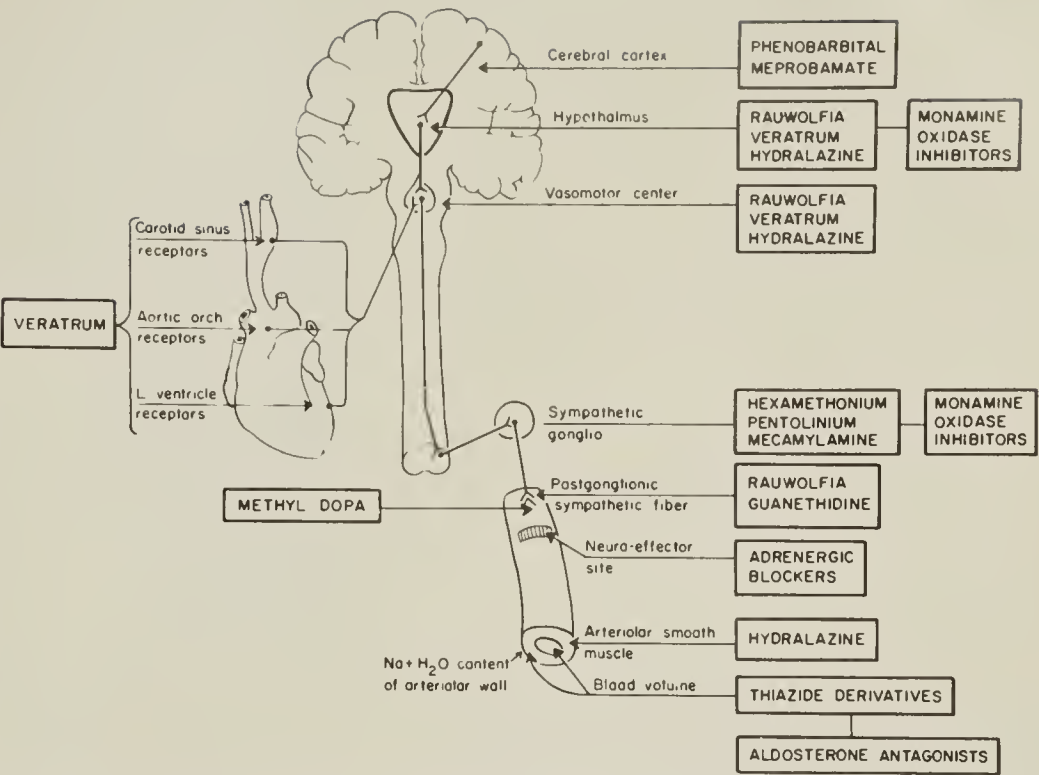


FIG. 3: Anatomic sites of action of various drugs that act to lower the blood pressure.

to reduce the total body content of sodium (e.g. sodium restriction and natriuretic drugs).

Hypertensive encephalopathy and other manifestations of *malignant hypertension* are indications for emergency parenteral therapy with either methyldopa, reserpine, hydralazine, diazoxide, pentolinium or trimethaphan camphorsulfonate. The immediate aim here is to reduce the pressure to a "safe" level before institution of oral maintenance therapy and further gradual reduction towards normal.

MANAGEMENT OF HYPERTENSION IN ELECTIVE AND EMERGENCY SURGERY

In the preoperative evaluation of hypertensive patients, careful attention must be paid to the hypertension itself as well as to the effects of the antihypertensive drugs. All measures employed in the management of hypertension depress the sympathetic nervous system, and patients who are taking sympathetic depressant drugs may become hypotensive under anesthesia or after mild blood loss in excess of what might be expected in patients who are not being treated with such drugs. However, the vessels—being distal to the site at which norepinephrine is released—are still able to respond; in fact, they are more responsive to norepinephrine than those of the normotensive patient who is not receiving drugs. Therefore the anesthesiologist should be prepared to combat anesthesia-induced hypotension immediate-

ly with vasopressors. It should also be kept in mind that the sympathetic depressant drugs have a prolonged action, especially guanethidine and pargyline. Even if discontinued for three days, they exert some hypotensive activity. However, within one week after termination of therapy most of this activity is lost.

Although many anesthesiologists express fear of the effect of sympathetic depressant drugs, hypotension caused by these drugs should be quite readily manageable during anesthesia. A much more difficult problem is presented by a drug effect that may lead to a response not so easily handled in the operating room. This is seen in patients who have been receiving diuretics for a long period of time. As previously mentioned, sodium depletion inhibits vasoconstrictor response and potentiates all other hypotensive agents, including the hypotensive effects of anesthesia. An absolute deficit of sodium and potassium is often not reflected in the concentration of these ions in the serum before surgery, but may be unmasked rapidly during or after surgery. Any abnormalities should be corrected preoperatively; or, if that is not possible, certainly during the operative procedure. It may be stated with emphasis that the long-term use of electrolyte-depleting diuretics is much more likely to cause hypotension that will be unresponsive to usual measures of correction than the use of sympathetic depressant drugs.

CHLOROTHIAZIDE INTENSIFICATION OF ANTIHYPERTENSIVE ACTION

PATIENT B. E.

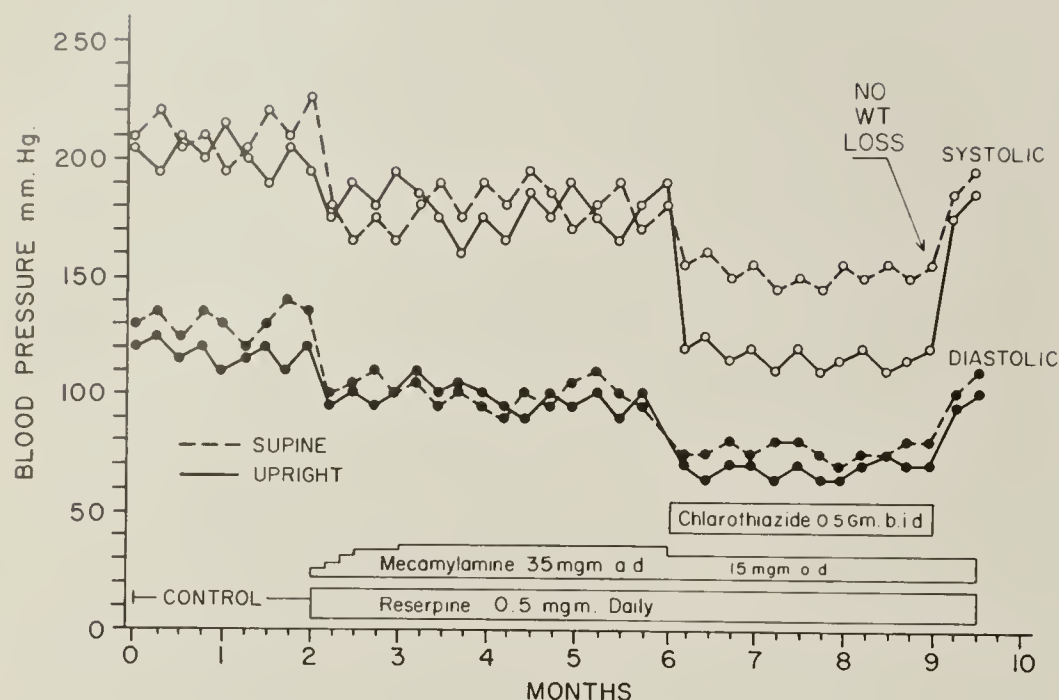


FIG. 4: Potentiation of a ganglionic blocking agent (mecamylamine) and reserpine by administration of a thiazide diuretic. It can be seen that the hypotensive action of the two antihypertensive drugs is increased by the addition of the diuretic. Consequently, a diminution of hypotensive effect would be expected following discontinuance of the thiazide drug. (From Heider, C. and Dennis, E.: Chlorothiazide potentiation of ganglionic blockade in patients with hypertension. *Ann. New York Acad. Sci.* 71:456, 1958.)

ELECTIVE SURGERY

If the patient has a pretreatment diastolic pressure of less than 120 mm. of mercury, it is possible to discontinue therapy completely for two weeks before operation without significant hazard, unless the blood pressure fluctuates strikingly, or cerebral or coronary artery disease is present. If the drugs cannot be stopped, vasopressors must be kept immediately available during operation for intravenous infusion or injection. Should the patient become unresponsive to these agents without being hypovolemic, the anesthesiologist should be ready to administer hypertonic salt solution (saline) at once.

A patient with more severe essential hypertension, with diastolic pressure before therapy above 120 or 130 mm. of mercury, is in a quite different situation. Here it is not appropriate to discontinue potent agents for an extended period of time before surgery, especially if the patient has vascular disease. The possibility of a major vascular catastrophe resulting from blood pressure breakthrough is much greater in this group of patients and may occur within five to seven days after termination of therapy. In severe hypertension, guanethidine or methyl-

dopa should not be discontinued for more than 72 hours preoperatively, and the anesthesiologist must again be prepared for hypotensive episodes requiring vasopressors. Diuretics can usually be discontinued 72 to 96 hours preoperatively even in these severely hypertensive patients. However, if they are stopped earlier than 72 hours before operation, it is possible that the enhancing effect of the diuretic on the sympathetic depressant (such as guanethidine) may be lost. The blood pressure may then escape rather seriously and rapidly and precipitate a vascular catastrophe.

Emergency surgery must necessarily be performed before any of the antihypertensive agents can be discontinued for a significant period of time. It must be realized that these patients who are taking sympathetic depressant drugs are especially sensitive to hypovolemia, and that a sharp drop in blood pressure may occur after the loss of as little as 50 cc. of blood. The capacity of the vascular system is actually increased in these patients. Therefore it is imperative to correct any blood loss. In fact, it is usually better to overcompensate somewhat, since mild overtransfusion is not a significant problem in these patients.

If the patient has received long-term diuretic therapy up to the time of emergency operation, by far the most important physiologic variable to consider is the concentration of sodium and potassium at the tissue level, as well as in the serum. These patients usually have a total body deficit of sodium and potassium, and that may become most evident with anesthesia. Even if the preoperative serum levels of these elements are normal, careful and slow intravenous replacement therapy should be begun. This must be intensified when intra- and postoperative electrolyte determinations reveal total body deficiencies of sodium and potassium.

Hypertension occurring during surgery often calls for prompt action to reduce the elevated blood pressure and suggests the presence of pheochromocytoma. Phentolamine (Regitine®, Ciba) is the agent of choice in this situation. This drug blocks the ability of the blood vessel to respond to norepinephrine and other vasoconstrictor substances, even though they are present at the neuroeffector site (adrenergic blockade). It also blocks sympathetic impulses when given in higher doses. To control a pheochromocytoma, repeated doses of 5 mg. at intervals of five minutes or more are adequate. On the other hand, when using this agent to prevent a rise in blood pressure due to sympathetic nervous system activity, larger doses may be necessary. Here a dose of 10 mg. is more appropriate, and as much as 60 mg. can be given over a period of one to two hours.

When the anesthesiologist desires a shorter acting compound than phentolamine for hypertensive episodes not due to pheochromocytoma, and one that provides blood pressure regulation at his fingertips, we would suggest the use of trimethaphan camphorsulfonate (Arfonad®). This drug has an evanescent effect and acts primarily through ganglionic blockade plus a histamine-like action. The anesthesiologist can readily regulate the blood pressure, irrespective of the direction it takes, by setting up a system that allows him to administer Arfonad and norepinephrine alternately. This requires separate intravenous lines, with little lag phase in the system. If, however, the hypertension is due to a pheochromocytoma, Arfonad will be ineffective since this form of hypertension is the result of vasoconstriction produced by a substance acting distal to the ganglia. □



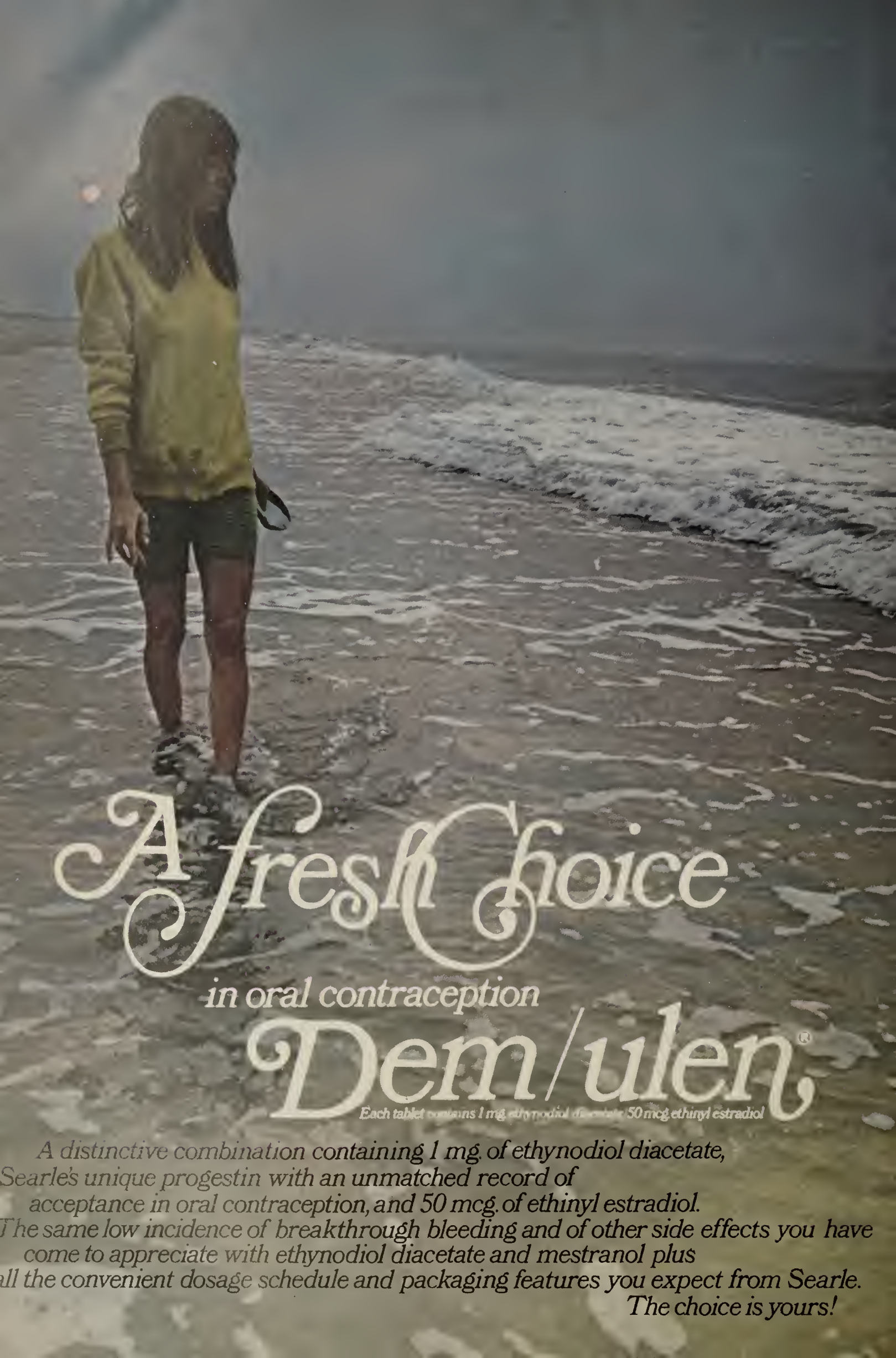
CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,3} leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated

after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contra-

ceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes

(tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13: 267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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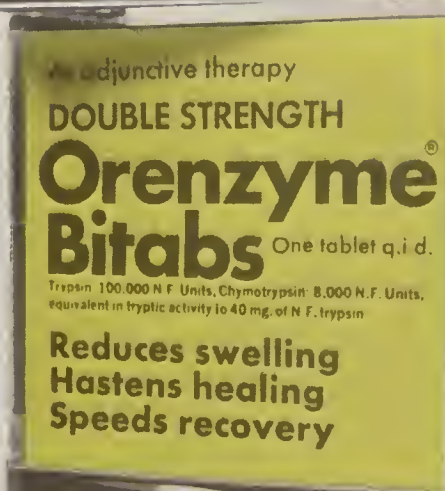


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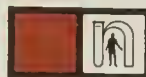
Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

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Correlation Of Retinal Vascular Changes With Cardiovascular Disease

Part II. Hypertension

Thomas B. Souders, M.D., ophthalmologist, Reading Hospital, West Reading, is questioned by William G. Leaman, Jr., M.D.

How does hypertension affect the retinal vessels?

A prolonged, significant increase in blood pressure results in thickening of the wall and narrowing of the lumen of the arteriole, a process identified as arteriolar sclerosis. Hypertensive changes may occur throughout the body, affecting the arterioles of many organ systems to a similar degree. Consequently, the extent of arteriolar sclerotic changes within the eye correlates well with changes elsewhere, notably in the renal and cerebral circulations.

What patterns of changes are seen in arteriolar sclerosis?

First, there is replacement fibrosis which is an increase in collagen and elastic tissue in all layers of the arteriolar wall, with narrowing of the vessel and characteristic changes in light reflex. Replacement fibrosis is identified with slowly advancing, mild to moderately severe hypertension with diastolic pressures which usually do not exceed 100 mg. Hg. Ischemic necrosis may then follow. This is a severe reaction of the vascular system to a rapid increase in blood pressure, usually associated with a diastolic pressure exceeding 120 mg. Hg.

What are the ophthalmic signs of arteriolar sclerosis?

Generalized attenuation may occur and may present a picture indistinguishable from that of involutionary sclerosis. Both generalized and focal constrictions

are found, thought to be the result of tonic contracture of the vessel walls. Although often difficult to recognize, the presence of attenuation is important because the extent of arteriolar narrowing correlates well with the height of the diastolic pressure over a prolonged period of time. The second important group of signs is that of changes in the arteriolar reflected light streak. As thickening and fibrosis of the muscular coat occur, the light reflex from the ophthalmoscope widens and softens. Eventually it may alter to such a degree as to resemble "copper wiring" and even "silver wiring", terms used to describe such changes. The third group of changes is that of alteration in the appearance of the A-V crossing. Bound by a common sheath, the A-V crossing may be changed so that the vein appears to be marked narrowed and seems to disappear behind the artery (called "nicking"). The vein may be displaced by the artery, assuming an S-shaped configuration. In severe sclerosis, the artery may compress the vein to such an extent that the distal portion of the vein dilates and the proximal portion constricts (banking). Tortuosity may occur as the arterioles increase in length, and extreme tortuosity of the fine arterioles about the macular is a valuable diagnostic sign in hypertension. Hemorrhages of varying degree may also result from ischemia, probably secondary to venous occlusion. Papilledema is the most dramatic sign of severe hypertension, indicating an extreme degree of vasospasm, fibrinoid necrosis and vessel damage.

How are the retinal hypertensive changes graded?

The most common grading system employed in evaluating retinal hyper-

tensive changes is that of Keith-Wagener-Barker, summarized as follows: Group I: Essentially benign hypertension, moderate arteriolar attenuation, often with focal constriction and all degrees of light reflex changes. Group II: Patient with continuously higher pressure, A-V changes and marked attenuation; hard exudates and tiny hemorrhages may be present. Group III: Hypertension severe enough to cause functional insufficiency to the retina, brain and other organs. Includes the changes of I and II with cotton-wool spots, retinal edema and hemorrhages. Group IV: Severe hypertension. All changes of Group III plus papilledema. It must be stressed that signs of replacement fibrosis may be minimal in the face of marked hypertensive changes of fibrinoid necrosis, depending on the age of the patient and rapidity of onset of the hypertension. Replacement fibrosis seems to protect the vessel from necrotic changes. The most severe, fulminating cases of hypertensive retinopathy occur in young people who develop hypertension rapidly before replacement fibrosis can occur, such as may happen in pheochromocytoma, eclampsia or occlusion of the renal artery. Eclampsia can convert a normal to a Group IV fundus within a twelve hour period.

Does the fundus appearance offer clues to the underlying cause of the hypertension?

No. The changes of hypertensive retinopathy merely reflect the stress of high blood pressure on the arteriolar walls and give no indication of the cause of the hypertension.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

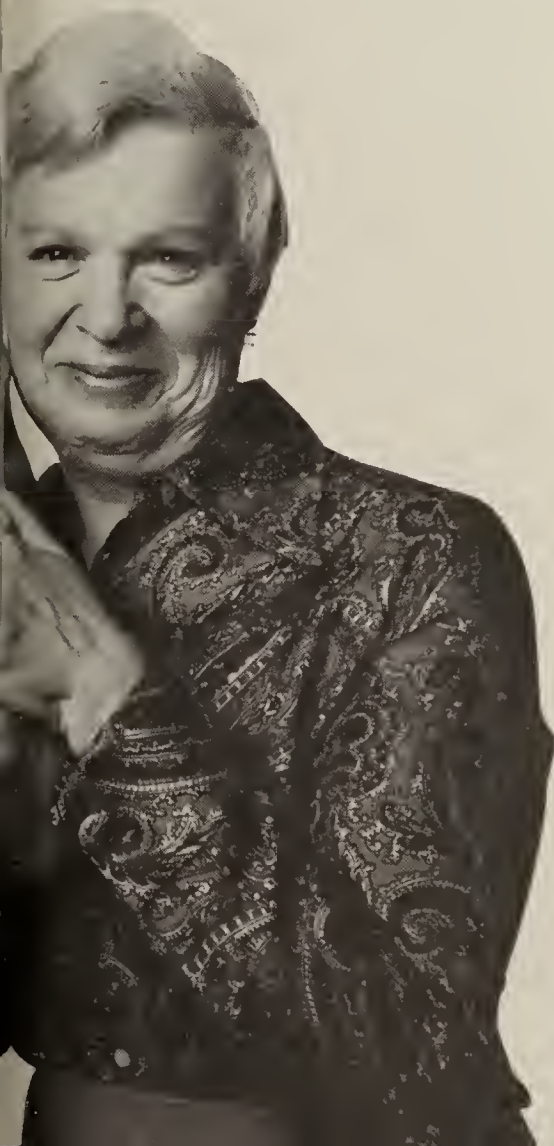
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Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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Safeguard Against Ovarian Cancer

John D. Paul, Jr., M.D.
Department of Obstetrics & Gynecology
Lancaster General Hospital
Lancaster

GUEST EDITOR

While the total cancer death rates during the last 35 years have been slowly dropping for all body sites combined; the death rate from ovarian cancer has been slowly rising. In the age span from 35 to 75 years, the number of deaths from cancer of the ovary ranked fourth highest after breast, uterus, and colon. The annual numerical death rate from cancer of the ovary in the United States is slightly over 10,000 women. It seems advisable to take a second look at ovarian cancer in general because this is an insidious disease with non-specific signs and symptoms. Prognosis generally is considered to be bad even when ovarian tumors are diagnosed early.

*'... if data are
critically reviewed,
warning signs of a great
number of ovarian
cancers have occurred
... prior to ...
diagnosis.'*

I think we have all fallen into the trap of blaming bad results in therapy on a "bad disease", and thereby blaming the disease process itself for our individual failure. Actually, if data are critically reviewed, warning signs of a great number of ovarian cancers have occurred either to the patient or to the

physician prior to the actual making of the diagnosis. Over 6 per cent of all ovarian malignancies occur in the 40 to 60 age group. Another 20 per cent occur after age 60. Therefore, a critical grouping of patients occurs for over 80 per cent of the reported cases.

It then appears that our index of suspicion must be raised in this particular age grouping of patients. I think that overall, ovarian masses in this age group should undergo prompt investigation without undue delay or procrastination on anyone's part. Many authorities list the five centimeter size as a pre-requisite for surgery. This is utterly illogical since in this age group, any palpable ovarian enlargement requires explanation.

M. Mintz, M.D., of Paris, France has recently published a series of 831 women who were studied for their adnexal masses. He evaluated these patients endoscopically by means of a laparoscope. The pelvis was visualized and endopelvic cytology was done. When there was a cystic structure large enough to raise a question, the cyst was aspirated endoscopically and the contents were evaluated chemically and cytologically. This study spanned a period of six years. A number of cases of early cancer was discovered by this method. To us here in America, aspiration of ovarian cysts sounds somewhat strange, in that 211 samples of cyst aspiration, 114 of these were found to be functional follicular enlargements and 45 organic cysts. All of these cysts were benign except two. This points out the fact that cystic enlargements of the ovary are

of much general less liability than solid tumors.

Are we then missing an important point in diagnosis? It would appear so. I feel that aggressive use of laparoscopy will prevent the loss of patients in whom "borderline" lesions are palpated. Little is lost from investigating these patients endoscopically. As experience of the laparoscope mounts, the overall bleak survival of the ovarian carcinoma may be reversed. Our European colleagues seem to be pointing the way to this facet of diagnosis. A high index of suspicion and aggressive management can ultimately transform late diagnosis into early diagnosis.

Treatment of this disease revolves around multiple entities. The mainstay is surgery when cases are confined to pelvic viscera and when masses can be removed. Most authorities agree that whenever possible all tumors should be removed surgically even if it involves sacrificing fairly large segments of viscera. Innovations in therapy today revolve around the use of multiple chemotherapeutic agents simultaneously. M. D. Anderson Clinic in Texas and Loyola University Oncology Service in Chicago are now tabulating sizeable series of cases. Conventional radiotherapy has a palliative effect in many tumors and may be curative in some. There is limited success with the use of therapeutic amounts of P_{32} in selected cases.

The day is usually darkest just before dawn. Perhaps aggressive endoscopy is the bright glimmer of light of a new day in the diagnosis of ovarian carcinoma.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.
 Altoona Hospital; fourth Thurs. ea. mo.
 Greensburg (Westmoreland Hosp.); first Tues. ea. mo.
 Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.
 Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.
 Uniontown Hospital; last Mon. ea. mo.
 Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT

OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971

I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Educational Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 20, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

DuBois Hospital; February 4—April 8, 1971

CODE KEY

C — Consecutive days
I — Intermittent
O — Circuit
PG — Postgraduate Traineeship
S — Designed for full-time specialists
 AMA—AMA Accredited Institution
 CES — Council on Education and Science, Pennsylvania Medical Society
 Hahnemann — Hahnemann Medical College and Hospital
 Hershey — Milton S. Hershey Medical Center
 Jefferson — Jefferson Medical College of Philadelphia
 Penn-Grad — University of Pennsylvania, Division of Graduate Medicine
 Pitt — University of Pittsburgh School of Medicine
 Pitt P.H. — University of Pittsburgh Graduate School of Public Health
 Penn State — Pennsylvania State University
 Temple — Temple University Health Sciences Center
 U. of Pa. — University of Pennsylvania School of Medicine
 Woman's — The Medical College of Philadelphia

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; \$35 fee (\$5 single session).

Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazleton State Gen. Hosp.; September 2, 1970—May 26, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazleton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazleton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster Gen. Hosp.; September 22, 1970—May 18, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17602.

Lancaster Osteopathic Hosp.; October 8, 1970—March 11, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602.

Lebanon; November 3, 1970—May 4, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lebanon; November 3, 1970—May 4, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14—December 2, 1970

I—RECENT ADVANCES IN MEDICINE; at Temple; 1 day ea. week; 32 hrs. AAGP credit applied for; \$50 fee. Contact Albert J. Finestone, M.D., Clin. Prof. of Med. Temple, 3400 N. Broad St., Philadelphia 19140.

Pottsville; September 24, 1970—May 27, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royle, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grand View Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 hrs. AAGP credit applied for. \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971

I/AMA—A PROGRAM OF CONTINU-

ING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS—CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for; \$25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September—November, 1970 and February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 10 weeks ea. semester; 40 hrs. AAGP credit applied for; \$25 fee ea. semester. Contact J. Martin Myers, MD., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September 24—December 3, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; every Thurs.; 10 weeks; 20 hrs. AAGP credit requested. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Norristown; September—November, 1970

I—THE PRE-SCHOOL CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics; 2 hrs. ea. day; 1 day ea. week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hrs. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia, 19139.

Philadelphia; September 30—December 2, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 20 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 6—December 15, 1970

I/S—BEHAVIOR THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Hosp. of U. of Pa.; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970—April 6, 1971

I—MEDICAL HYPNOSIS; by The Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; \$150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 12—December 14, 1970

I/S—FAMILY THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Phila. Child Guidance Clinic; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13—December 15, 1970

I/S—MARITAL THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at the Phila. Marriage Council; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 14, 1970—March 3, 1971

I/AMA—PSYCHIATRIC PROBLEMS OF CHILDREN; at Hahnemann; every Wed. (except holidays); 18 weeks; 36 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. of Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 8—December 24, 1970

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF ALCOHOLISM, DRUG ADDICTION AND SEXUAL PROBLEMS; at The Institute of Pennsylvania Hospital; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; \$75 fee for 10-week session, \$150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 26—December 14, 1970

I/S—THERAPY OF PROBLEMS IN SEXUAL ADJUSTMENT; by The Institute of Pennsylvania Hospital and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 7—March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS; at The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February—April, 1971

I/S—TREATING SEXUAL INADEQUACY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March—April, 1971

I/S—PSYCHOPHARMACOLOGY; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. ea. day; 1 day a week; 8 weeks; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March—May, 1971

I/S—DRUG ABUSE AND ACUTE PSYCHOSIS; by The Institute of Pennsylvania Hosp. and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee.

Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; April 7—May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; \$50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

October 5, 1970; Philadelphia

C—CARDIOPULMONARY RESUSCITATION INSTRUCTORS' TRAINING COURSE (for physicians, dentists, registered nurses and administrators); by Pa. Heart Assoc.; at Emergency Care Research Institute; \$20 fee; limited to 30 registrants. Contact Emergency Care Research Institute, 913 Walnut Street, Philadelphia 19107.

October 20-21, 1970; Philadelphia

C—HYPERTENSION-1970; by Jefferson, Pa. Heart Assoc., American Heart Assoc., and Heart Assoc. of Southeastern Pa.; \$40 fee (\$60 non-members); Limited to 150 registrants. Contact Miss Carole Mintz, American Heart Assoc., 44 E. 23rd St., New York 10010.

October 21, 1970; Harrisburg Hospital

C—CARDIOPULMONARY RESUSCITATION INSTRUCTORS' TRAINING COURSE (for physicians, dentists); by Pa. Heart Assoc. and South Central Pa. Heart Assoc.; \$20 fee; limited to 50 registrants. Contact South Central Pa. Heart Assoc., 2915 Wayne St., Harrisburg 17111.

October 27, 1970; Pittsburgh

C—EMERGENCY RESUSCITATION TEAM TRAINING (for medical and paramedical personnel); by Pitt. and Pa. Heart Assoc. as part of the Western Pa. RMP. Contact Mr. Gary Craun, Room 30, VA Hosp., University Dr. C, Pittsburgh 15240.

November 10, 1970; Pittsburgh

C—CARDIOPULMONARY RESUSCITATION INSTRUCTORS' TRAINING COURSE (for physicians, dentists) at Pitt; by Pitt. and Pa. Heart Assoc.; \$20 fee; limited to 50 registrants. Contact Postgraduate Medical Program, Pitt, 1188 Scaife Hall, Pittsburgh 15213.

November 13, 1970; Philadelphia

C—CARDIOPULMONARY RESUSCITATION INSTRUCTORS' TRAINING COURSE (for physicians, dentists, registered nurses and administrators); at Emergency Care Research Institute; by Pa. Heart Assoc.; \$20 fee; limited to 30 registrants. Contact

Emergency Care Research Institute, 913 Walnut Street, Philadelphia 19107.

November 18, 1970; Pittsburgh

C—EMERGENCY RESUSCITATION TEAM TRAINING (for medical and paramedical personnel); by Heart Assoc. and Pitt. Contact Mr. Gary Craun, Room 30, VA Hosp., University Dr. C., Pittsburgh 15230.

May 6—7, 1971; Pittsburgh

C—PRE-INFARCTION PATIENT; by Pa. Heart Assoc.; at Chatham Center; 7 hrs. ea. day; 14 hrs. AAGP credit applied for; \$25 fee. Contact Royce J. Britton, Prg. Dir., Pa. Heart Assoc., P. O. Box 2435, Harrisburg 17105.

CHEST DISEASES

November 30—December 11, 1970; Philadelphia (Hahnemann)

O/AMA—A WORKSHOP IN RESPIRATORY INTENSIVE CARE; by Greater Delaware Valley Regional Medical Program; 10 consecutive days; 8 hrs. ea. day; max. registration—15; 80 hrs. AAGP credit applied for. Contact R. F. Johnston, M.D., Head, Sect. of Chest Diseases, Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 3-14, 1970 and March 1-12, 1971; Philadelphia

PG—POSTGRADUATE COURSES IN BRONCHESOPHAGOGY; at Temple. Contact Charles M. Norris, M.D., Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

November 11, 1970; Franklin

C/AMA—CURRENT CONCEPTS OF DIABETES MELLITUS; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 10, 1971; Sharon

C/AMA—MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

November 11, 1970; Philadelphia County Medical Society

November 1970; Philadelphia County Medical Society

March 1971; Berks Co. Med. Soc., Reading
April 14, 1971; William Penn Hotel, Pittsburgh

May 1971; Conemaugh Valley Mem. Hosp., Johnstown

June 1971; Lehigh Valley Club, Allentown

O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit \$5 fee. Contact Comm. on Emerg. Med. Serv.,

Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

November 4, 1970; Scranton

C/AMA—DIFFERENTIATION AND MODERN MANAGEMENT OF ANEMIAS; by Hahnemann and Lackawanna Co. Chapt. of AAGP; at Elks Club; 6 hrs. Contact August F. Frattali, M.D., Dir., 100 N. Main Avenue, Scranton, Pa. 18504.

November 11, 1970; Franklin

C/AMA—CURRENT CONCEPTS OF DIABETES MELLITUS; by Jefferson and Penn State; at Voyager Motor Inn; approved for 3 hrs. AAGP credit; \$10 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 16-19, 1970; Lancaster

C—CLINICAL THERAPEUTICS 1970: EMERGENCY MEDICINE (1970 Scientific Assembly of PMS); by CES; at Host Farm Resort Motel. Contact Robert L. Evans, M.D., CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

December 7-11, 1970; Philadelphia

C/AMA—EMERGENCY ROOM CARE (I Physicians); by Hahnemann; at Marriott Motor Hotel; 25 hrs. AAGP credit applied for; \$125 fee. Contact Wilbur W. Oaks, M.D., Prg. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 3, 1971; Harrisburg

C—DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

INTERNAL MEDICINE

Johnstown; September—November, 1970
Kittanning; September—November, 1970
Meadville; September—November, 1970
New Castle; September—November, 1970

Pittsburgh; September 16—December 9, 1970
Pittsburgh; September 17—December 10, 1970

I—SEMINARS IN PATIENT CARE; at Staunton Clinic; 2 hrs. a day; 1 day a week; 13 weeks; \$100 fee; Max. regis.: 15; 26 hrs. AAGP credit approved. Contact Rex A. Pittenger, M.D., Chief Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

York Hospital; September 17, 1970—April 29, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; \$40 fee (\$8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 14, 1970—May 12, 1971; Philadelphia

I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; \$150 fee (\$70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

November 16-19, 1970; Philadelphia

C/AMA—CANCER CHEMOTHERAPY (2nd Symposium) by Hahnemann; at Sheraton Hotel; 26 hrs. AAGP credit applied for; \$125 fee. Contact Isadore Brodsky, M.D., Prg. Dir., Hahnemann; 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

October 7, 1970; Philadelphia

C—SYMPOSIUM: RENAL AND ELECTROLYTE DISORDERS & ANNUAL TOLLAND MEMORIAL LECTURE; at Nazareth Hospital; by Medical Staff; 4 hrs. AAGP credit approved. Contact Charles A. Syms, M.D., Exec. Dir., Education Committee, Nazareth Hosp., Philadelphia, Pa. 19152.

OBSTETRICS & GYNECOLOGY

December 3 and 4, 1970; Philadelphia

C/AMA—OFFICE GYNECOLOGY; two-day seminar; by Jefferson; at McClellan Hall; \$40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1971; Hershey Motor Lodge

C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; \$10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

PEDIATRICS

November 4-6, 1970; Children's Hosp. of Philadelphia

C—RESPIRATORY FAILURE IN INFANTS AND CHILDREN; by Amer. Acad. of Pediatrics, U. of Pa. and Children's Hosp.; 20 hrs. Contact Leonard Bachman, M.D., Course Coordinator, Children's Hosp., 1740 Bainbridge St., Philadelphia 19146.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park

C—SPORTS MEDICINE CONFERENCE by CES and Penn State. Contact CES Pennsylvania Medical Society, 20 Erford Rd. Lemoyne 17043.

⊙ Indicates membership in the Pennsylvania Medical Society at time of death.

Robert W. Kiley, Drexel Hill; Jefferson Medical College, 1944; age 49; died June 2, 1970. He was a surgeon and associate director of surgery at Mercy Hospital. He was also on the staff of Misericordia and Riddle Memorial hospitals. Surviving are his wife, two daughters and two sons.

⊙ Thomas H. Meikle, Troy; Jefferson Medical College of Philadelphia, 1926; age 70; died May 28, 1970. His wife, a daughter and a son, Thomas Meikle, M.D., survive.

⊙ David Rose, Wallingford; Jefferson Medical College, 1924; age 69; died June 15, 1970. His wife and a son survive.

⊙ Michael G. Wohl, Miami Beach, Fla.; Medico-Chirurgical College, 1912; age 81; died June 20, 1970. He was a physician, educator and author during his more than fifty years in practice. He was the founder and former chief of the Nutrition Clinic at Philadelphia General Hospital, the chief consultant at the Albert Einstein Medical Center, both divisions, and chairman of the Committee on Nutritional and Metabolism of the Pennsylvania Medical Society. His wife the former Rose B. Hillerson, M.D., and three sons, George T. Wohl, M.D., Joseph S. Wohl, M.D., and Milton A. Wohl, M.D., survive.

⊙ James W. Speelman, Pittsburgh; University of Pittsburgh School of Medicine, 1926; age 69; died June 15, 1970. A retired U.S. naval commander he served during World War II in a naval base hospital. Surviving are his wife and two daughters.

⊙ Anthony J. Staab, Pittsburgh; Georgetown University School of Medicine, 1934; age 63; died June 13, 1970. Survivors include his wife and two brothers.

⊙ George Toth, Yukon; Jefferson Medical College, 1924; age 70; died May 24, 1970. His wife and a daughter survive.

⊙ Paul A. Petree, Towson, Md.;

Jefferson Medical College, 1914; age 91; died January 24, 1970. He specialized in neurology and psychiatry and served as assistant superintendent at Harrisburg State Hospital. No survivors are listed.

⊙ Richard G. Canfield, Pittsburgh; University of Pittsburgh School of Medicine, 1940; age 54; died June 1, 1970. He was a physician on the staff of Magee Womens, Presbyterian-University and West Penn Hospitals. Survivors include his wife, two daughters and a son.

Sidney L. Sattenstein, Yountville, Calif.; Georgetown University School of Medicine, 1947; age 66; died June 7, 1970. His wife and four sisters survive.

James H. Reinish, Wyncote; Hahnemann Medical College, 1936; age 59; died June 4, 1970. His wife, a daughter and a son survive.

⊙ Abraham M. Rechtman, Philadelphia; Temple University School of Medicine, 1921; age 73; died May 30, 1970. Formerly he served as chief of staff for orthopedic surgery at Albert Einstein Medical Center Northern Division. Survivors include his wife and a daughter.

⊙ Sidney Kallaway, Shamokin; Medico-Chirurgical College, 1916; age 81; died May 31, 1970. In 1969 he was honored by the local medical association for his years of service to the community. Survivors include his son and a sister.

⊙ Lewis W. Gerhart, Selinsgrove; Temple University Medical School, 1939; age 57; died May 20, 1970. He was a member of the American Psychiatric Association and the American Association for Mental Retardation. No immediate survivors are listed.

Jacob Walker, Philadelphia; Jefferson Medical College, 1913; age 80; died June 26, 1970. He was a former associate professor at Jefferson Medical College and former chief of obstetrics and gynecology at the Albert Einstein Medical Center. Surviving are his wife, a daughter and a son.

⊙ Charles E. Lerch, Reading; Jefferson Medical College of Philadelphia, 1905; age 92; died May 30, 1970. He was a past president of the Berks County Medical Society. Surviving are two sons.

⊙ Lewis C. Druffner, Avoca; Jefferson Medical College, 1917; age 75; died June 22, 1970. He practiced medicine in Lackawanna County for more than fifty years and served as chief of staff at Taylor Hospital for more than twenty years. He is survived by his wife, three daughters and two sons, L. C. Druffner, Jr., M.D., and Charles R. Druffner, M.D.

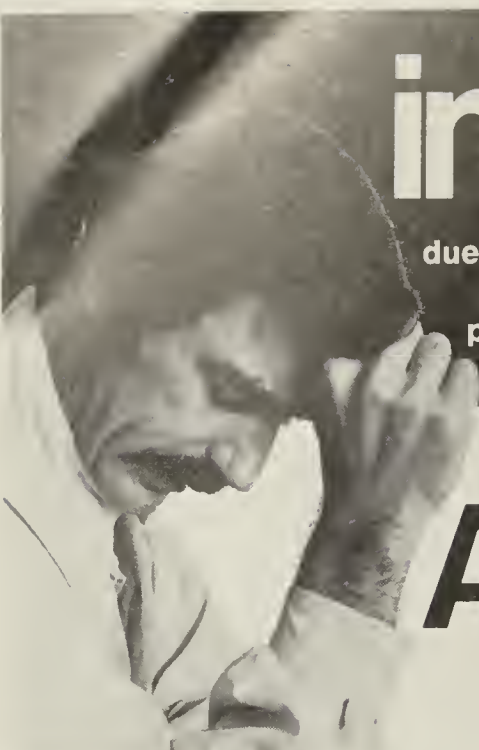
⊙ Wilbert J. Helzlsouer, Dravosburg; Western Reserve University School of Medicine, 1937; age 59; died June 5, 1970. He is survived by his wife, a son and two daughters.

⊙ Edward M. Kent, Wexford; State University of New York, Upstate Medical Center, 1932; age 63; died June 6, 1970. Dr. Kent, a thoracic surgeon, performed the first open heart surgery in Pittsburgh. He served as past president of Allegheny General Hospital's medical staff and American Association of Thoracic Surgery. He was also clinical professor and chairman of thoracic surgery at the University of Pittsburgh School of Medicine. His wife, a son and two daughters survive.

⊙ Henry B. Kobler, Philadelphia; Medico-Chirurgical College, 1899; age 91; died June 2, 1970. His wife and daughter survive.

Flora E. Wasserman, Philadelphia; Cleveland University of Medicine and Surgery, 1890; age 100; died July 20, 1970. She specialized in ophthalmology. No survivors are listed.

⊙ Theodore C. Greary, Bala Cynwyd; Hahnemann Medical College and Hospital, 1924; age 69; died June 1, 1970. He was a fellow of the American College of Surgeons and a diplomat of the International College of Surgeons. Survivors include his wife, a son and two daughters.



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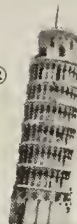
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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
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Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evengelliste, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tietz, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zimoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypochlosteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:883, 1958. 6. Dsol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

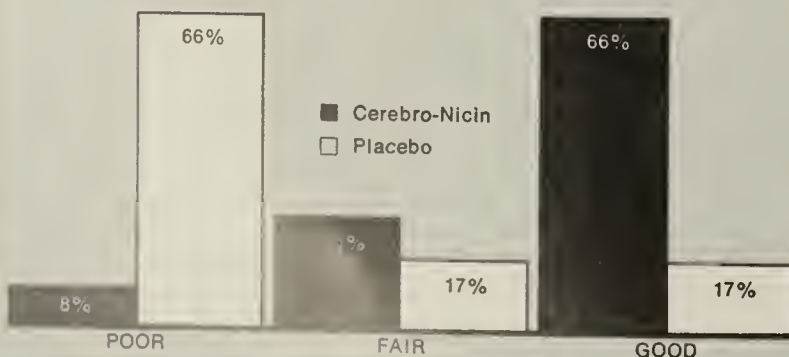
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*A Double-Blind Study of Cerebro-Nicin Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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1970 SCIENTIFIC ASSEMBLY

Theme: CLINICAL THERAPEUTICS -- 1970: EMERGENCY MEDICINE

THE PENNSYLVANIA MEDICAL SOCIETY

HOST FARM RESORT MOTEL
Lancaster, Pennsylvania

MONDAY, NOVEMBER 16

9:00 a.m. - 12:30 p.m. PMS SEMINAR

THERAPY OF
CARDIOVASCULAR EMERGENCIES
*(Organized in cooperation with
Hahnemann Medical College and Hospital)*

9:00 a.m. - 12:00 noon
PENNSYLVANIA CHAPTER,
AMERICAN ACADEMY OF PEDIATRICS

1:30 p.m. - 4:00 p.m.
PENNSYLVANIA ACADEMY OF PHYSICAL
MEDICINE AND REHABILITATION

2:00 p.m. - 4:30 p.m.
PENNSYLVANIA ALLERGY ASSOCIATION

2:00 p.m. - 5:00 p.m.
PENNSYLVANIA SOCIETY OF
INTERNAL MEDICINE AND
AMERICAN COLLEGE OF PHYSICIANS

2:00 p.m. - 5:00 p.m.

A PROGRAM FOR NURSES
AND ALLIED PROFESSIONALS

8:00 p.m. - 10:30 p.m.

A REALISTIC APPROACH TOWARD
UNDERSTANDING OF THE
DRUG SCENE

TUESDAY, NOVEMBER 17

9:00 a.m. - 1:00 p.m. PMS SEMINAR

CONTINUING MEDICAL EDUCATION

10:00 a.m. - 12:00 noon
PENNSYLVANIA ASSOCIATION OF
CLINICAL PATHOLOGISTS

1:30 p.m. - 3:30 p.m.
PENNSYLVANIA SECTION, DISTRICT III,
AMERICAN COLLEGE OF OBSTETRICIANS
AND GYNECOLOGISTS

2:00 p.m. - 5:00 p.m.
AMERICAN CANCER SOCIETY,
PENNSYLVANIA DIVISION, INC.
and PHILADELPHIA DIVISION

2:00 p.m. - 5:00 p.m.
EDUCATION WORKSHOPS

8:00 p.m. - 9:30 p.m.

ALCOHOLISM

WEDNESDAY, NOVEMBER 18

9:00 a.m. - 12:00 p.m. PMS SEMINAR

GASTROINTESTINAL EMERGENCIES
*(Organized in cooperation with
Jefferson Medical College)*

All Day

PENNSYLVANIA PSYCHIATRIC SOCIETY
"Eugenic Sterilization"

1:00 p.m. - 5:00 p.m.

PENNSYLVANIA SOCIETY OF
COLON AND RECTAL SURGERY

2:00 p.m. - 4:00 p.m.
UROLOGICAL ASSOCIATION
OF PENNSYLVANIA, INC.

2:00 p.m. - 4:00 p.m.

PENNSYLVANIA ACADEMY OF
OPHTHALMOLOGY AND OTOLARYNGOLOGY
2:00 p.m. - 4:00 p.m.

SEMINAR: A TEAM APPROACH TO GASTRO-
INTESTINAL EMERGENCIES

9:00 a.m. - 11:45 a.m.

WORKSHOPS: 1. Ostomy Care
2. Endocrinology

THURSDAY, NOVEMBER 19

9:00 a.m. - 12:30 p.m. PMS SEMINAR

DIAGNOSIS AND TREATMENT OF
ACUTE AND CHRONIC
RESPIRATORY PROBLEMS

*(Organized in cooperation with
University of Pittsburgh School of Medicine)*

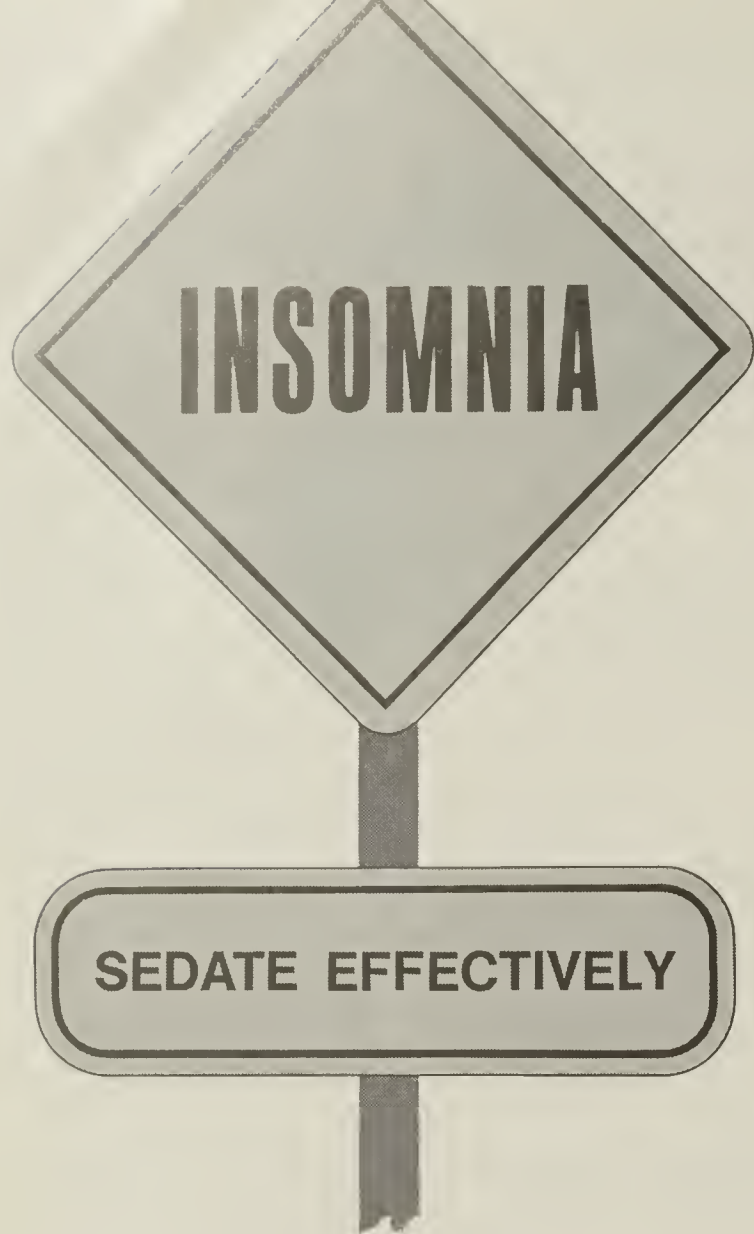
1:00 p.m. - 4:00 p.m.

PENNSYLVANIA CHAPTER OF
AMERICAN COLLEGE OF CHEST PHYSICIANS
and

PENNSYLVANIA THORACIC SOCIETY

2:00 P.M. - 5:00 p.m.

INTERNATIONAL COLLEGE OF SURGEONS



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PENNSYLVANIA
MEDICINE

meetings

NOVEMBER

Seventeenth Annual Meeting of the Academy of Psychosomatic Medicine, November 15-19, 1970, The Princess Hotel, Hamilton, Bermuda.

Twelfth National Conference on the Medical Aspects of Sports, November 29, 1970, Boston, Mass.

Annual Clinical Convention of the American Medical Association, November 29-December 2, 1970, Boston, Mass.

Fifty-fifth Annual Scientific Assembly, November 2-5, 1970, Palmer House, Chicago, Ill.

Pennsylvania Medical Society Annual Scientific Assembly, November 16-19, 1970, Host Farm Resort Motel, Lancaster.

DECEMBER

Twenty-Ninth Annual Meeting of the American Academy of Dermatology, December 5-10, 1970, Palmer House, Chicago, Illinois. For information contact: Frederick A. J. Kingery, M.D., Secretary-Treasurer, American Academy of Dermatology, 2250 Northwest Flanders, Portland, Oregon.

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Pennsylvania Licensed Physicians — part time — to cover out-patient emergency service in 274-bed accredited general hospital. Write: Office of Ad-

ministrator, Lower Bucks Hospital, Bristol, Pa. 19007.

Wanted—Psychiatrists for Mental Hygiene Clinic operated within 951-bed modern neuropsychiatric hospital; immediate opening at salary range \$22,918-\$25,538; general practitioners interested in psychiatry welcomed; excellent working conditions in active cultural center and university affiliation; liberal fringe benefits; non-discrimination in employment. Write: Hospital Director, VA Hospital, Leech Farm Road, Pittsburgh, Pa. 15206, or call collect (412) 362-2000, ext 208 or 209.

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Emergency room physician—full time; Accredited 300 bed general hospital; active approved internship and residency programs; excellent benefits. Submit resume to: Administrator, Robert Packer Hospital, Sayre, Pa. 18840.

POSITION WANTED

Orthopaedic surgeon, certified, 42, married, seeks solo or partnership. Write Box 580, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

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*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

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(fluorouracil)
cream/solution

for the treatment
of solar/actinic keratoses...
a topical alternative
to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche[®] (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex[®] (fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*



2/2/68—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest by sharply defined reactions. Intervening skin, also treated, shows no response to therapy.

2/19/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals lack of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream
Applied twice daily—resolves
solar or actinic keratoses.

new
Efudex®
(fluorouracil)
cream/solution



For full prescribing information, please see the following page.

Roche
introduces



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cream/solution
the new standardized topical
for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (e.g., CO₂, urea, α -fluoro- β -alanine) which are inactive.

Studies in man with topical application of ¹⁴C-labeled Efudex demonstrated insignificant absorption as measured by ¹⁴C content of plasma, urine and respiratory CO₂.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local

reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.



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their Atropine content . . .
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



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Tablet in bottles of
100, 500 and 5000

Capsule in bottles
of 100, 500 and 1000

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Dr. Barrett Addresses House Of Delegates

are reported in detail to this House and I hope every member will read every report. Therefore, it would be unnecessary duplication for me to try to enumerate them.

But, there are particularly important steps and accomplishments of your Society activities over the past year which should be emphasized for the benefit of the uninformed, uninvolved members who may ask, "What does the State Society do for me?"

When a member asks what the Society does for him, he usually is thinking of himself as an individual. There are the more obvious services, such as health and accident, accidental death and dismemberment and life insurance at group rates much cheaper than he can get individually; the medical benevolence program for financial aid for himself or his widow and children; a loan program for his children who may pursue medical and other careers; assistance in the defense of malpractice claims; scientific programs, seminars and meetings; and a superb monthly journal, PENNSYLVANIA MEDICINE. Those things are only a beginning.

The services he often does not see but takes for granted are the many performed by the councils and a very competent administrative staff.

If the many activities and accomplishments listed in the various reports of the Board of Trustees, the councils, commissions and committees of your Society do not completely answer the question of what the State Society does for the members, this may be summarized as follows:

1. It represents the physician and his professional interests in governmental matters and carries his views to the public and its organizations.
2. It gives the physician a strong voice in issues being raised by others.
3. It gives the physician the power to endure against those who would tamper with and debilitate the nature of his art.
4. It provides the physician with an ethical structure which would otherwise be imposed by others.
5. It works to determine and maintain the quality of medical care through medical, graduate and continuing education and peer review mechanisms.
6. Through the strength of unity it defends and carries in knowledge and acquaintanceship the strength for aggressive, positive action.
7. It designates elected leaders to act and speak for the membership as a whole on every occasion.

Some of the councils, commissions and committees once had a tendency to meet only to react to problems, such as those referred to them by the House of Delegates or the Board of Trustees. Such reaction is still necessary and will continue to be so.

However, more than ever this year I have noted that some of our councils and their components have given that extra touch of aggressiveness, imagination, experimentation and innovation to their thinking and their actions. This is the service and leadership of which we can all be proud.

Innovations in the past year have included:

1. The appointment of an Interspecialty Committee offers great potential for a close and meaningful interplay between the Pennsylvania Medical Society and eighteen statewide specialty society groups of our members. The general feeling of interest and strength

conveyed by their first meeting was most interesting.

2. A Lay Advisory Committee which was appointed and met for the first time in June. Even some of your officers in attendance did not fully appreciate the multitude of council activities related by staff members for the understanding and identification of this new committee. Already, positive results of their interest have become apparent to the Board.
3. A scientific seminar in cooperation with the Pennsylvania Osteopathic Association was well attended and much worthwhile. In addition, the Osteopathic Association has agreed to nominate representatives to the Pennsylvania Medical Society—Blue Shield Review Committee in the western part of our Commonwealth.

Health Care Manpower

The manpower shortage in the health care field today is our most critical problem. It is the bottleneck in the medical service and delivery program. It is all too real in both the professional and paramedical areas, not because of an actual decrease in the numbers working in those fields but because of a rapid proportional increase in the population, scientific advances, health education of the public by the medical profession, an affluent society and a series of oversold federal health legislative programs. Nor is the shortage due to a lack of intelligent, properly motivated young people who wish to study in these fields but who are denied their career choices because there is a deficiency of places and programs in which to train them.

In its efforts to improve the public's health through lectures, newspaper articles, television and radio programs, books, posters and individual recommendations for regular examinations, the medical profession has met a responsibility and in so doing, has itself contributed to the relative shortage of manpower. The public has learned to demand health care as a *right*. The government has magnified the problem by further increasing the demands on physicians through enabling Social Security amendments. Titles XVIII and XIX and additional proposed amendments promise care for patients without providing for adequate manpower to deliver that care.

This manpower shortage is almost equally acute in all sectors of the health care field.

Medical Education

Education is the key word and basic requirement of the medical profession and is inescapably linked to medical science. The expansion of medical education capabilities is a *must* so that more students will be trained, so that the continuing education of practicing physicians is assured and so vast numbers of allied health care groups may be trained.

These steps cannot be taken without the cooperation of the public, the legislature, the medical schools and the Pennsylvania Medical Society. For too long, each has acted separately, or not at all, in the areas of medical education with the human tendency of one group to blame the other for deficiencies. All are interested; all are concerned. A concerted approach most certainly should produce a more adequate supply.

The training of a physician is a long, expensive program.

Medical schools in the past have been limited by their physical plants and the number of teachers they could afford to hire. The failure of the public, through inadequate state and federal appropriations, to supply the additional funds for training more physicians has been the primary cause of the present physician shortage. At no time have physicians or medical societies advocated limiting the number of physicians trained. For the most part, it has not been government but philanthropic endowments to the schools and family resources for the tuition which have supplied this nation with physicians.

Physicians and their medical societies have, since the Flexner Report in 1910, constantly insisted upon the inspection and accreditation of medical schools, hospitals and residency programs so as to insure to the public the quality and competence of all licensed physicians. But physicians have organized, supervised and maintained these activities, not the government nor the public.

As affluent as this country is, few families could afford to provide a medical education to their children at the actual cost today. All must be subsidized in some way, especially those from disadvantaged families. The individual student contributes seven to fourteen years of his life in training; the public, through government, should indeed provide appropriate facilities in which he may train.

Medical School Expansion

Although the number of medical schools has increased from 72 to 103 in the past 40 years, until the last two or three years individual medical schools have been unwilling to increase the number of the students accepted each year. All of their reasons seemed logical, such as limited laboratory or clinical facilities, restricted funds, a shortage of teaching faculty and a need to uphold the requirements of professional excellence. In most instances, the schools simply did not have the money to expand enrollments.

No longer are those reasons accepted at face value. The medical schools, the universities, state legislatures, the federal government, the medical profession and the public in general must share the responsibility for the deficiencies of today. We do have enough willing and capable young people to supply the demand.

Qualified students who wish to study medicine *must* have the opportunity to do so. The situation demands more physicians. To organize future physician clubs in high schools or talk of the advantages of a medical career with college students and then have over 50 per cent of them shunted off into other academic fields because of a lack of space in our medical schools is not only unkind, it is unrealistic in the face of today's and tomorrow's needs. The medical profession must continue to demand the necessary financial assistance provided through taxes to support the expansion of medical schools and assist every needy student to obtain a medical education if he can qualify. The profession and the medical schools must act together to convince the public and its legislative bodies that increased financial assistance to students in medical schools is imperative if we are to overcome the physician shortage.

Medical schools must innovate in curricula in ways that will better utilize the facilities already available, the teaching services of faculty already on full-time salaries, qualified clinicians of the community on a part-time basis, large community hospitals with active post-graduate programs.

Medical schools and government must be made to realize that, as essential as research is for the advancement of sci-

ence, medicine and our civilization, it should not outweigh the need to train physicians to care for patients. Government must restrict research grants in such a way that those who are not totally in the field of research will spend at least 75 per cent of their time teaching students. The pendulum must swing back, at least for the next 10 years, to a required effort on the part of our schools to produce physicians to serve people.

Through the mechanism of government subsidy to medical schools on a per-student basis, rather than by political negotiation, and by a government subsidy to students who qualify scholastically, these manpower deficits must be met by the general public through taxation.

Through the mechanism of government incentives to students, possibly in a manner similar to the Berry Plan for the armed services, communities needing physicians must be served. The federal and state government, the medical schools, the medical societies and the communities must plan together to overcome these shortages.

The American Medical Association and the American Association of Medical Colleges are conducting major efforts to encourage medical schools to expand their enrollments as rapidly as possible without jeopardizing the quality of medical education. But the profession and the medical schools must act together to make the public and our governing bodies aware of the inescapable fact that increased financial assistance to students and medical schools is the imperative step to meet the physician deficit.

I recommend that this be started by a meeting of the deans of the medical schools in Pennsylvania with knowledgeable representatives of the Pennsylvania Medical Society: (a) to discuss ways and means of increasing medical school enrollment; (b) to consider appropriate recommendations to the Pennsylvania Legislature and the Congress; and, (c) to apprise the general public of the tax responsibility that goes with its right to medical care.

Allied Health Care Personnel

The explosion in scientific knowledge in the past ten years has greatly expanded both the needs and potentials for clinical assistants. Because of the relative shortage of physicians, it is imperative that we carry out the training and utilization of clinical assistants in every possible discipline which will extend the effectiveness of a physician.

These individuals are an essential part of the health team. After proper selection and a prescribed, supervised course of training, they should be certified by the Commonwealth. They must be given responsibility, recognition and opportunities to advance laterally and vertically in the health field. In each position, their pay must be consistent with their competence.

I recommend that this Society continue to assist the various health care groups to define their educational requirements and establish training standards, and that we assist the Board of Medical Education and Licensure in revising the Medical Practice Act so that these other members of the health care team can be appropriately certified.

Medical Practice Act

The Medical Practice Act in Pennsylvania has not been revised, and then only in a minor way, since 1963. The Board of Trustees, recognizing the many weaknesses and inadequacies of the act, has appointed a committee to work with the Board of Medical Education and Licensure to update it.

Such a revision must provide greater latitude in the

premedical educational requirements of applicants and the curricula of medical schools, and a less rigid definition of the acceptable period and type of clinical training required for licensure.

Progressive and imaginative steps must be included to permit the training of great numbers of the various paramedical groups and dignify their abilities with appropriate certification.

Serious consideration also should be given to the establishment of one board of education and licensure for the examination and licensure of all physicians in the Commonwealth.

I recommend that this House of Delegates (a) support the revision of the Medical Practice Act; (b) encourage the training and certification of all allied health care groups; and (c) support the concept of a single medical examining board in Pennsylvania.

Continuing Medical Education

The continuing education of a practicing physician today is of critical importance to him and to the quality of medical care he provides to his patients. In fact, it will become in the very near future as critical and as criticized as is the quality and quantity of medical care today.

The criticisms and discussions about reexamining and recertifying physicians must be answered by the profession through a program of continuing education.

"Courses and formal educational offerings must be selected to complete the total pattern and spectrum of the physician's educational activities and to fit his 'educational profile.' These offerings, their nature, timing, content and character of presentation must be interrelated in planning to fit into and help stimulate the 'motivation' of the user. They must be tailored to the needs of practice and not to the problems and programs of the major health centers from which they or their purveyors originate. Such planning, relating to the chief foci for such courses—the community hospital, the professional society and the major health center (medical school)—will require the correlated efforts of those concerned in each of these sectors." Thus spoke William A. Sodeman, M.D., Sc.D., in the September, 1969 issue of *Diseases of the Chest*.

The responsibility for organizing such programs, developing individual educational profiles, and selective training for individuals, dare be entrusted only to the Pennsylvania Medical Society in this Commonwealth.

The integration and synchronization of all postgraduate medical school programs, national medical societies, and specialty society programs directed toward the practicing physician must be correlated on a long-range basis. Structured into the hospital programs at times, the total program can better meet local and individual needs, avoid unnecessary duplication of programs and effort, conserve resources—particularly of manpower, and provide meaningful, long-range physician educational opportunities.

The Council on Education and Science has arranged and conducted scientific programs in the more sparsely settled areas of the Commonwealth while some medical schools have provided similar programs in thickly populated areas, usually in their own sphere of influence.

Almost no determination of the need for a particular program in a specific area was established in any of the above instances. No complete evaluation of the effectiveness or merits of a program was made. No synchronization of plans or programs between the major health centers was achieved. Evaluating the hit-or-miss, catch-as-catch-can

overlapping and duplication has been the complete responsibility, or fate, of the individual physician.

Almost as important is the failure to utilize most effectively the diminishing professional manpower. This will become more critical in the immediate future.

For approximately five years the Council on Education and Science has, through its Advisory Committee on Continuing Medical Education, studied this subject. The 1967 report of this committee made specific recommendations to the Board of Trustees with detailed descriptions of a proposed body to be organized that would evaluate physician needs, correlate and synchronize the various programs throughout the State and innovate varied and appropriate educational tools and mechanisms to assist physicians in their continued education.

In its wisdom, the Board has insisted upon continued study and refinement of the details of such a body, its relationship with other teaching organizations and a reasonable assessment of financial needs and sources.

The meeting of July 23, 1970, with representatives of allied physician education groups was encouraging and, I believe, evidenced the cooperation of the majority of them.

In addition to the hundreds of physician man-hours devoted to the study and development of the proposed structure over the past five years, the Pennsylvania Medical Society is spending almost \$60,000 per year on continuing physician education. One hundred dollars or even ten dollars would be too much to spend on an exercise in futility.

Although the Board has not acted favorably upon the council's recommendations for the establishment of a Pennsylvania Medical Continuing Education Institute, it has not directed the council to discontinue its efforts on the subject nor has the council's proposed budget for 1971 undergone major reductions.

Realizing that the first draft of any instrument is not likely to be perfect and that, with appropriate provisions for amendments, necessary refinements will be made when indicated, the structure and components of the suggested subsidiary organization seems to be a workable one that would be both responsive and responsible to the Pennsylvania Medical Society.

"Elevating and maintaining the standards of medical education; extending medical knowledge and advancing medical science" is the tool which will help this Society to further its constitutional purposes.

The cost of such a statewide educational program is likely to be about \$120,000 for each of the first two or three years. Probably, little more than half that amount would be required in the first year of organization. Other scientific and medically oriented groups which expect to participate would also be expected to assist in defraying the costs.

The organizational structure could represent participating groups who would be elected by trustees of the corporation (the Board of Trustees of the State Society) as indicated in the schematic drawing prepared by the council and attached to this address.

I recommend that: (a) the Pennsylvania Medical Continuing Education Institute be founded, for the primary purpose of promoting the continuing education of physicians and allied health care groups; (b) the organizational structure be a separate corporation with 15 trustees who shall also be the Board of Trustees of the Pennsylvania Medical Society, and governed by a representative board of directors elected by the trustees; (c) as many as necessary of the

present staff now serving the Council on Education and Science be allocated to the activities of the institute; (d) the educational programs and scientific meetings, activities and responsibilities be transferred to the institute; (e) advice of legal counsel be obtained regarding the possible and advisable options of organizing such a body; and, (f) a physician medical educator be employed, on a part-time basis at first, not only to develop and direct appropriate educational programs but also to help mold and direct the growth of the institute.

I fully realize the magnitude of the decision I am asking you to make. Inevitably, many problems will arise but the Board of Trustees, the council and our capable staff can solve them. The physicians of Pennsylvania should be able to creditably continue their education in Pennsylvania. Allied groups on the health-care team look toward medicine for help and guidance. We can drop the ball or run with it. Let us expand the format of the past 122 years. Let us again demonstrate the leadership for which this Society is known.

The above subject is an integral part of an answer to the growing outside pressures for relicensure or recertification of physicians.

The AMA Physician's Recognition Award requires 150 hours of certified study that can be achieved in a variety of ways over a three-year period. The California Medical Association requires up to 200 such hours in various specified categories in the same time period.

The Oregon Medical Society has made certified continuing education a requisite for membership.

This House of Delegates is to consider a supplemental report of the Council on Education and Science which recommends that the 150 hours specified for the AMA Physician's Recognition Award be made a minimum requirement for membership in the Pennsylvania Medical Society.

I recommend that this House support the above recommendation of the Council on Education and Science.

Legislation and PaMPAC

During the two years of the current session of the state legislature, the Society's Council on Governmental Relations has been extremely fortunate in achieving a major portion of its legislative goals. Perhaps, in the order of their importance to medicine, would be the passage of the Uniform Anatomical Gift Act, the Consent for Minors to Medical Treatment, the Renal Dialysis Law, and the Professional Corporations Act. The Society also was instrumental in having vital amendments added to the drug, device and cosmetic measure to permit telephone prescriptions and to the public employees bargaining measure so that strikes might be prevented in hospitals and so that groups of professional employees, such as nurses and even physicians, could be represented by their professional associations.

We have not been as successful in getting physicians' relief from malpractice circumstances, such as changing the Doctrine of Informed Consent or giving physicians protection when participating in mass immunization programs. However, efforts are continuing in these directions.

The Committee on Relationship with Allied Professions continues to make significant progress, especially in liaison with the nursing professions.

Our members must realize that the officers and the staff of this Society are forced to wage an uphill contest with

many legislative bills if members and county medical societies have failed to do their parts at the local levels.

When individual members do not talk to their state legislators, congressmen or senators, when county societies make little effort to convey the professional opinion to political representatives or have meetings with the legislators to discuss the interests of medicine, the efforts of our representatives at the Capitol can be futile.

With much time and effort, on three different occasions the chiropractic bill has been returned to a committee of the House. This bill, S-254, would mandate Blue Shield to pay for chiropractic services in their offices for all of the 5½ million subscribers in Pennsylvania. Presently this bill is in the Rules Committee. It must be defeated when it again comes up after the November elections.

It is human nature, and so easy, to blame the actions of others rather than admit our own deficiencies. It is so easy to find reasons why not to do those things which are tedious, irksome or time-consuming. It is so easy to "let George (or Bob) do it."

The AMA on the national level and the Pennsylvania Medical Society in the Commonwealth will be completely impotent unless individual physicians awake from their complacency. Legislative efforts can be guided by financial support of and personal contact with individual representatives. It will not be done through wishful thinking or hospital staff room debates.

The Pennsylvania Medical Political Action Committee is the political arm of the physician and an excellent mechanism to help accomplish what most of us are too busy to do individually—work toward the election of competent citizens who are sympathetic to the medical point of view. Now is the time to lend your assistance through personal efforts and through contributions. Next January the candidate you did not help may not be very sympathetic to your views on socialized medicine. In fact, he may be too busy to see you.

PaMPAC is especially limited this year in what it can do toward supporting those candidates who will listen to physicians. This is primarily due to the failure of many county societies to include PaMPAC dues on the same bill as the county society dues, and the failure of individual members to accept this responsibility for the profession.

I recommend that all county medical societies be urged to include PaMPAC membership dues as part of their regular dues statements.

Although PaMPAC provides physicians with a mechanism for participating in good health care legislation, there is no automatic way to inform legislators about the merits or faults of specific proposals before them.

Only the personal contact of a legislator and his constituent provides the "sesame" to good legislation or the defeat of bad legislative bills. One voter alone will not influence any man in political office. The question he inevitably asks is, "How many votes do you represent?"

Only through concerted action of the medical society and its legislative arm, PaMPAC, will the slightest impression be made upon men in political office. The solo practitioner is still a potent, capable influence in medicine; there is no place in politics for the solo politician.

I recommend that every county medical society build a fire under its legislative committee and insist upon (a) at least annual meetings with all legislators from that county; (b) that specific physicians be charged with a personal contact of each county legislator, on a personal and social basis, if possible; (c) that the county Woman's Auxiliary

be requested to assist in both activities; (d) that the State Society position on each proposed piece of legislation which affects medical care or the profession be sent to the individual legislator with a note over the signature of the individual physician charged with that contact.

Council on Medical Service

The areas of responsibility and concern covered by the Council on Medical Service are too numerous to list. Its major activities and accomplishments are recorded in the annual report to the House. But it is incomplete. There is a constant and continuing stream of services to the Society and individual members which are not recorded, yet are day-to-day necessities.

As might be expected, progress has been made in some areas and no change effected in others. For example, there is improved liaison with the Department of Public Welfare as a result of meetings with the Secretary, his deputies, and later, a liaison committee. However, in spite of repeated requests over the past three years, the Society efforts to have usual and customary fees paid under the Medicaid Program have been constantly thwarted by the failure of the Legislature to appropriate sufficient money for the purchase of Blue Shield—Blue Cross prepaid insurance for the beneficiaries of Title XIX, and by some reluctance on the part of the Department.

If the Welfare Department would purchase those insurances, its beneficiaries immediately would be removed from the "charity" classification and have a wider choice of physicians; physicians would have no reluctance in completing the Blue Shield forms instead of the much debated and objectionable invoice transmittal form, Pa. 259-S, and they would receive a reasonable compensation for their services. These patients have been guaranteed by law the quality and quantity of medical care that is necessary, acceptable, professionally good and patient-oriented.

These patients by law are a public responsibility, not the sole responsibility of the medical profession. The public has the responsibility of providing for such patients and, therefore, must prevail upon the Legislature to provide the necessary appropriations to purchase prepaid Blue Shield—Blue Cross insurance for them.

I recommend that the Society take whatever steps are necessary, including legislative ones, to have the Department of Public Welfare provide prepaid hospital and medical insurance contracts for all of its beneficiaries.

Although members of the Council on Medical Service have been meeting with public welfare officials, welfare's own advisory committee has not been meeting regularly. Moreover, this department committee has but one physician representing the State Society. Action on problems arising in the field of mental health and mental retardation, whether with patients or facilities, is influenced by a department employee who is an ex officio member of the committee. This is unacceptable and the State Society has so informed the Secretary of Public Welfare.

The case of acutely disturbed mental patients has always been a concern and problem to physicians. The interpretation by the former Attorney General of Section 404 of the Mental Health/Mental Retardation Act of 1966 is totally unacceptable to the State Society. It would eliminate a commitment procedure of eighty years standing which permitted two physicians and two attorneys to commit a mental patient upon the request of a member of the patient's family. To require a court procedure, as this new

interpretation would do, so that the citizen's right to due process is preserved would greatly delay the proper treatment of the patient, cause considerable expense to the family and, perhaps, even endanger the patient's contacts.

Prepaid Insurance Programs

Blue Shield has sought and accepted considerable guidance in the development of doctor profiles, in the adjustment of individual physician's usual and customary fees, in the improved processing of Medicare Part B claims and in the development of liaison with the Bureau of Health Insurance of the Social Security Administration and the Senate Finance Committee regarding Medicare and Medicaid.

I recommend that these and similar areas of cooperation be pursued actively by the Society by whatsoever means may be required.

Attempts to develop a statewide hospitalization and medical insurance program for our members has not been successful. This was in part due to the unwillingness of some of the Blues to do so and, in part, to the refusal of some county medical societies to alter their present program. This is still a possibility.

I recommend that the State Society continue to develop such a Blue Shield—Blue Cross program for those counties who wish to participate.

Social Security Administration

Liaison with several officials of the Social Security Administration has been more realistic than at any previous time. Although this has not resulted in any spectacular breakthrough, it has developed a better understanding of that department by our representatives and has given the department a clearer understanding of the problems in Pennsylvania and the advances and the potential of our State Society.

Since the beginning of the usual and customary fee payments by Blue Shield, the 90th percentile has been used in the payment of physicians. Because this method was believed to be fair and was approved by PMS, it was also used in the payments for services to Medicare beneficiaries. The Bureau of Health Insurance decided last Spring that, beginning on July 1, 1970, all intermediaries must use the 83rd percentile. The Bureau intent was to reduce the payments for physician services.

Blue Shield officials met with Bureau of Health Insurance representatives, accompanied by representatives from the Council on Medical Service to protest this change. One reason for the objection was that actual payments on the 90th percentile plan in Pennsylvania under this program were much less per service per patient than is the national average.

Because of proposals in the Congress to reduce payments under Medicare to the 75th percentile, no directive has as yet been issued.

Blue Shield was advised to continue to implement the new physician profiles for their private utilization committee review programs.

The individual physician profile will continue to be developed as previously. An individual physician may request a copy of his usual and customary charges. Changes in the accepted charges for any or all services will be adjusted automatically by Blue Shield on the basis of charges re-

ported on the requests for payment. They plan to revise this every six months.

The Council has persisted in developing the most reasonable and satisfactory relations possible and Blue Shield has been cooperative and responds in a responsible manner. Our members are sure to recognize that such a relationship can exist only between an insuring body which has physicians on its board of directors and in key official positions. No other insuring organization and no governmental department will listen or react in a similar manner.

Peer Review

Peer review committees were initiated in Pennsylvania in 1957 and have developed increasing sophistication in the interim. This is, of course, not universal throughout all of the counties and there is a considerable variation in effectiveness in the various areas.

Review committees have been appointed in all councilor districts but function effectively in only seven. However, the addition of nineteen specialty advisory committees under the program greatly enhances the effectiveness of this activity. Most groups receive very few cases to review; at least one has received no cases in the past year.

But the above review primarily has been on the fees charged; only occasionally has the quality of care been questioned.

The cost of medical service rendered is rightly of concern to the patient, to the insuring program and to physicians; the quality of care provided is the primary responsibility of physicians. Since the organization of the American Medical Association in 1847 and the Pennsylvania Medical Society a year later, the quality of care provided has been our concern.

The incorporation of specialty boards to certify those who have been acceptably trained in the various disciplines and the development of residency review programs to insure such training, have all been steps formulated by the profession without public or governmental pressures.

A quality control mechanism has been included in the AMA Mediredit plan proposed to the Congress in H.R. 18567 (Fulton-Broyhill). This is a fair and equitable plan which deserves the unqualified support of all physicians. It would provide patients with prepaid insurance of their own choosing, whether they pay income tax or not, on a sliding scale of tax credits for the basic coverage. Additional benefits could be purchased by adding components to the basic coverage.

It is imperative that all physicians take positive action to help develop a prepaid health insurance program at a predictable cost. The alternative could easily be governmental action similar to that which has already occurred in Canada, especially in the Province of Quebec where the government, in response to the pressures of six large unions, has decreed that all specialists will be on a fixed salary from the government. The time remaining is growing short.

I recommend that the Pennsylvania Medical Society officially endorse the AMA Mediredit Bill and actively work toward its passage by the Congress.

Foundation for Medical Care

On August 12, 1970, the Board of Trustees approved in principle the concept of a Pennsylvania Medical Society Foundation for Medical Care. Such a giant step into the future of medical care will require careful, prolonged study and planning, an unremitting dedication to the interests of

patients and the profession, a prolonged period of organization, patience and perseverance in the negotiations with other purveyors in the health care field, and a great amount of money.

Although the concept is relatively new, it is not original. The San Joaquin Medical Society, some of the Permanente groups and the Medical Association of Georgia are experimenting in this area. Recent discussions between your representatives and HEW officials have indicated the possibility that such a Foundation could operate on a statewide basis in Pennsylvania.

Most of the costs of organization may be obtained as a federal grant. Blue Shield could provide cost estimates for professional services and the Blue Cross plans, for hospital care.

Based on those estimates, with estimates of inflationary costs, the Foundation would guarantee the total cost of medical and hospital care in Pennsylvania on a yearly basis.

Safeguards would be provided for this Society and its members. The incentive of up to 45 per cent of any savings being returned to the Foundation and the possibility of prorated fees for service in the event of excessive expense are possibilities.

This would be a positive plan by the State Society to insure the cost of medical care in Pennsylvania. It would provide a closed panel, prepaid concept with voluntary participation by patients and physicians.

It could help to check the rising costs of health care and might reduce the rate of hospital usage. It would provide an additional incentive for our profession to further check the spiralling costs of health care. This is a challenge to the medical leadership in this Commonwealth.

I recommend that this House of Delegates; (a) approve in principle the concept of a Pennsylvania Medical Society Foundation for Medical Care; (b) direct the Board of Trustees and Council on Medical Service to proceed with a study of the possibilities and develop a specific plan for the organization and operation of a medical care foundation; and (c) direct legal counsel to study the necessary steps and requirements between the Society and the Social Security Administration and between the Society and other purveyors and insurers of medical and facility care. I further recommend that the plan or plans, opinions of legal counsel, costs and recommendations be submitted to the House of Delegates at its regular 1971 session.

Public Service

As with all of the other components of the State Society, the Council on Public Service has responsibilities that exceed the resources that can be made available to it. From attending the council meetings and observing its activities and projects, I think it is clear that the council knows what should be done in the areas of public and professional relations but that it cannot do it with the funds it has available. Frankly, I am amazed that the council is able to carry out so many commendable activities—a real tribute to the effective way in which it uses every dollar it receives.

However, the multitude of essential activities in which it is engaged is but a drop in the bucket compared to the expenditures of the forces arrayed against the goals of the profession.

To put our annual total public service budget in perspective, it is less than the cost of producing a one-hour quality television program.

In our public service activities, you get what you are

willing to finance. Perhaps you get even more than that, but only because of the personal sacrifices of the physician members of the council and because of a dedicated, knowledgeable staff.

A look at the activities of this council, as listed in its annual report, should amaze you when you realize they are accomplished with an allocation of about \$9 of your dues of \$75.

The Council describes its dilemma in the introduction to its annual report where it expresses its concern over the lack of membership awareness of State Society activities and its reluctance to divert funds from needed public communications to membership communications.

I recommend that the reference committee and this House in considering the introductory portion of the council's report, give the council specific guidance on the direction in which you would have it turn.

In Conclusion

The members of this House of Delegates in the next three days will carefully review all of the actions of the officers, the Board of Trustees, the councils, commissions and committees, and the staff. I am sure that your actions will continue to follow the past practice of approving those activities which are in the best interest of the public and the profession. However, I beg of you not to stop there.

From you, the Board and other components of the So-

ciety require more than approval and support. The rapid advances in all scientific fields, the changed thinking of the public in health matters, the great public and political resurgence of demands for total health care insurance and legislation, the manpower shortages and maldistribution in all of the health care fields, the great need for physician participation at all levels of political activity, the rapid growing need for continuing physician education because of the explosive expansion in most of the scientific fields, and the urgent need to check runaway health care costs—especially in our hospitals—are only a few of the problems that our profession must face and help to solve. We dare not turn our backs or run away from them.

Solutions to these problems will require our united efforts. Pennsylvania has produced the necessary leaders in the past to do the task that needed to be done and it can do so now.

Two of the greatest challenges for us today are an Institute for Medical Continuing Education and a Foundation for Medical Care. For budgetary, financial or other reasons, these progressive ideas could be shelved and councils would have less work to do and their expenditures considerably lessened.

The Society could probably operate within its present income if additional projects are not undertaken, but is that our sole objective?

Will the Pennsylvania Medical Society move forward—or drift backward? The House must decide. Pennsylvania medicine has the leadership. Let it lead!



"THE OLD ORDER CHANGETH..." as Park M. Horton, M.D., chairman of the PMS Board of Trustees, to the left in both pictures above, removes the president's badge from William A. Barrett, M.D., and presents the past president's medallion.



SCENES FROM THE annual state dinner dance—an evening of honors—appear above. Across the top of the page delegates and guests dance during dinner. In the left hand picture, center of page, R. William Alexander, M.D., Reading, retiring chairman of the Council on Public Service, presents the group Benjamin Rush Award to Mrs. J. Michael Stott, past president of the Philipsburg Junior Women's Club, who accepted on behalf of the club. The right-hand picture shows Dr. Alexander presenting the individual Benjamin Rush Award to Mrs. Ruth Harris, of Snow Shoe. These awards are presented yearly to the individual and the group in the state exhibiting the greatest devotion to caring for the needs of their fellow humans. At the bottom of the page, on the left, Park M. Horton, M.D., chairman of the PMS Board of Trustees, places the badge of president on William A. Limberger, M.D., who was sworn in as president following the banquet. To the right, Dr. Limberger and William A. Barrett, M.D., immediate past president, relax after a day filled with society business and ceremonial affairs.

7-0081-0011

Christmas House Call on the Doctor



Season's Greetings

FROM THE EDITORS AND STAFF OF PENNSYLVANIA MEDICAL JOURNAL

DECEMBER, 1970

INCLUSION OF CHIROPRACTORS
IN BLUE SHIELD DEFEATED

One of the final actions taken by the State Legislature before the 154th General Assembly officially ended November 30 was the defeat of Senate Bill 254, by a vote of 95 to 70. This is the Senate-passed measure, which, if given an affirmative vote in the House, would have included chiropractic coverage in Blue Shield. A brief report of the stormy history of the bill appeared in the October issue of PENNSYLVANIA MEDICINE, noting that the House of Representatives defeated the bill this summer, but that a political maneuver caused it to be re-referred to another committee, thereby revitalizing it. It was thought that efforts might be made to recommit it to committee again rather than vote on it. This would have given supporters of the measure a strong position in introducing similar legislation after December 1, when the new General Assembly is seated. The action taken by the House November 17 should discourage the introduction of similar legislation next year. "Finis" to the history of Senate Bill 254 has been written.

SCIENTIFIC ASSEMBLY
'MOST SUCCESSFUL'

One of the most successful of the PMS Scientific Assemblies, both in terms of numbers of participants and enthusiastic reception, concluded November 19 in Lancaster. Well over 900 registrants, including more than 600 M.D.'s, took part in scientific programs arranged by various specialty societies as well as general sessions and seminars and workshops for nurses and allied professionals. The PMS Interspecialty Committee met during the assembly, as did a number of specialty societies. The PMS seminars for physicians covered these subjects: "Cardiovascular Emergencies," "Understanding the Drug Scene," "Continuing Medical Education," "Alcoholism," "Gastrointestinal Emergencies" and "Acute and Chronic Respiratory Problems."

'PANDEMIC' IS DESCRIPTION
OF VD INCIDENCE IN NATION

The American Social Health Association (ASHA), at its recent meeting in New York, called on President Richard M. Nixon to appoint a commission to study the serious venereal disease situation in the United States. For the first time since World War II, and the first time since the development of antibiotics, the incidence of venereal disease has been declared "pandemic." The other times the term has been used were at the end of World War I and of World War II, according to James McKenzie-Pollack, M.D., medical director of ASHA.

SPECIAL TASK FORCE
COMPLETES HEARINGS

A special task force of the Advisory Committee for Mental Health and Mental Retardation of the Department of Public Welfare has completed public hearings on admission and commitment procedures of the mentally ill. Testimony for the most part concerned the problem of involuntary commitment, and ranged from the demand for preventive detention of individuals who give any indication they might prove dangerous to an equally strong demand that there be no involuntary commitments at all. The task force is expected to take the testimony into consideration in formulating proposed amendments to the Mental Health and Mental Retardation Act governing admission and commitment procedures. In a resolution passed at the 1970 Annual Session the State Society has urged that protesting mental patients be committed on the signatures of two physicians to assure the patient's right to immediate treatment. The current interpretation of the 1966 act requires a court order which can impose delay and hardship to the patient and his family.

HOUSE OF DELEGATES APPROVES
PARTICIPATING DOCTOR'S PLAN

The PMS House of Delegates, at its Annual Session in October, supported action of the Board of Trustees to approve the Blue Shield Participating Doctor's Agreement, based on a recommendation of the Council on Medical Service. (See letter inserted in the September issue of PENNSYLVANIA MEDICINE). The recommendation states: "The Pennsylvania Medical Society continues to approve, in principle, the Participating Doctor's Agreement since Blue Shield will provide the individual doctor's fee profile for specific procedures upon request by the physician; and since Blue Shield has provided to each participating doctor an explanation of the usual, customary, and reasonable (UCR) criteria and its application, and since Blue Shield will prepare a position paper to be distributed to all participating doctors outlining the policy and procedures of the Prevailing Fee Program."

DOCTOR WARNS OF CRISIS
IN GROWING DRUG ABUSE

William F. Wieland, M.D., director of the Philadelphia Community Mental Health Consortium, Methodone Program, and a participant in the drug abuse program at the Scientific Assembly said that a crisis in American life must occur to bring about a halt to drug abuse. He added that drug addiction itself might be that crisis.

PMS TO STUDY WAYS TO AID
AMA PRECEPTORSHIP PLAN

The Student American Medical Association chapters in Pennsylvania are planning a preceptorship program through which students study primary patient care by assignment to an individual physician with part of the time spent in a local hospital. The Council on Education and Science is studying ways to assist in the program.

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PENNSYLVANIA MEDICINE



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PENNSYLVANIA MEDICINE



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**It doesn't let monilia begin
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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased

intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin— maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney— rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions— urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.



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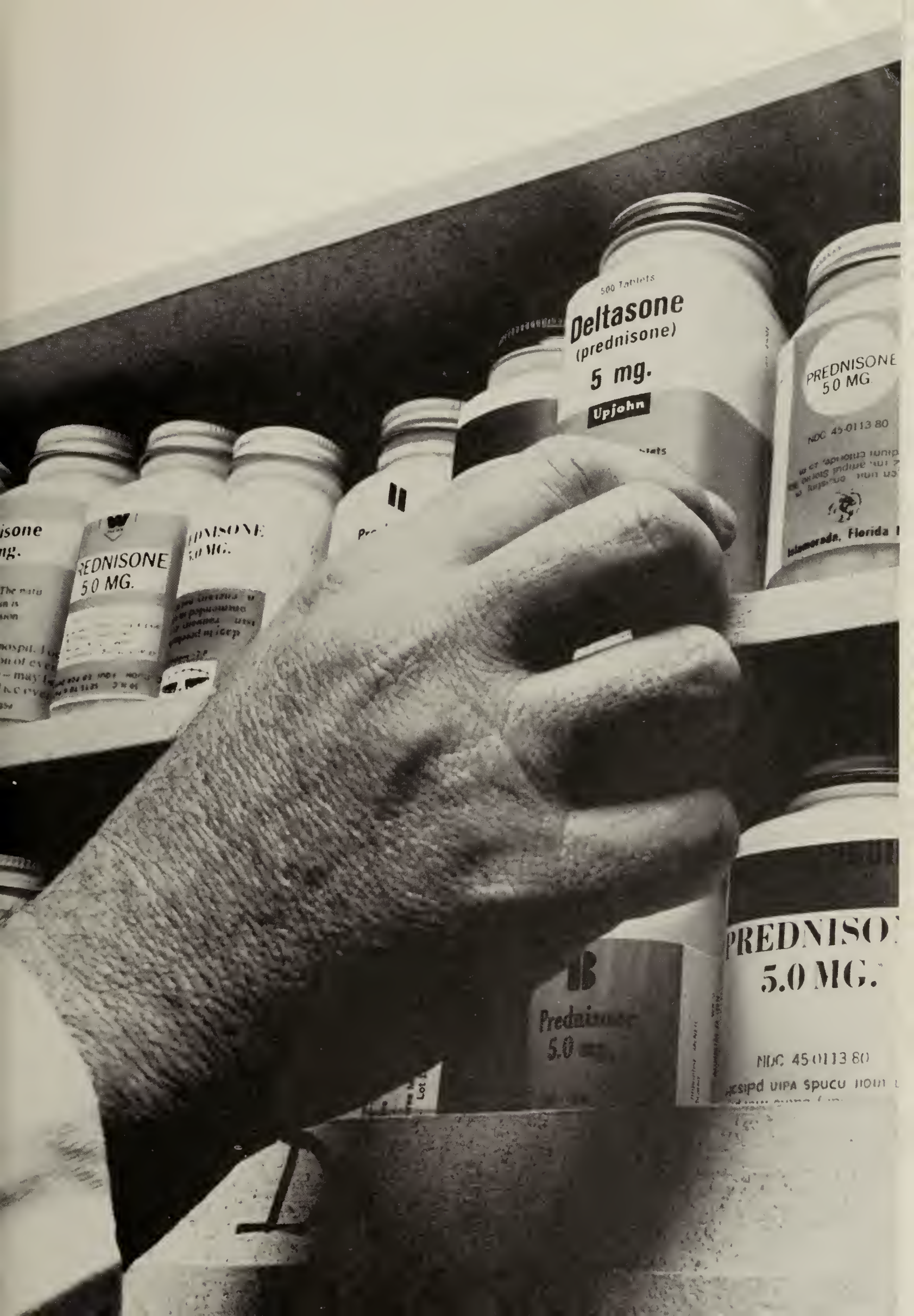
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocortical insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptotically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective main-

tenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluoro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

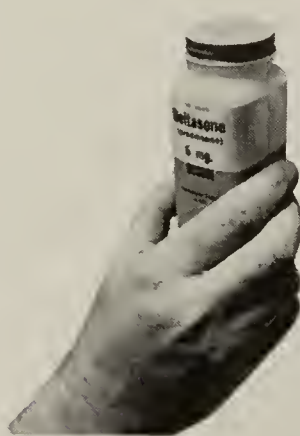
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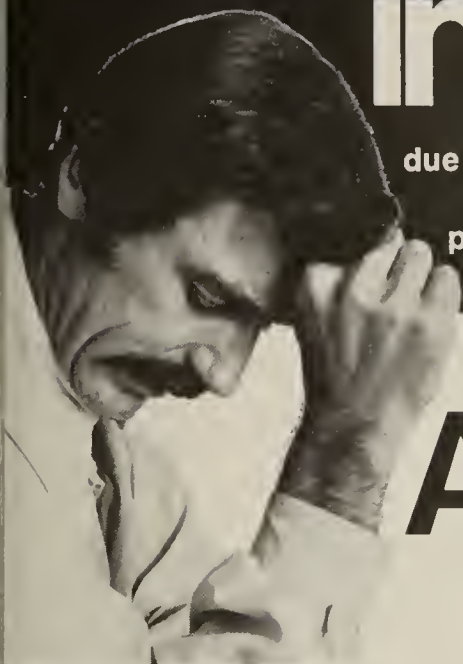
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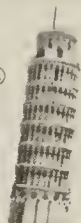
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting, abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

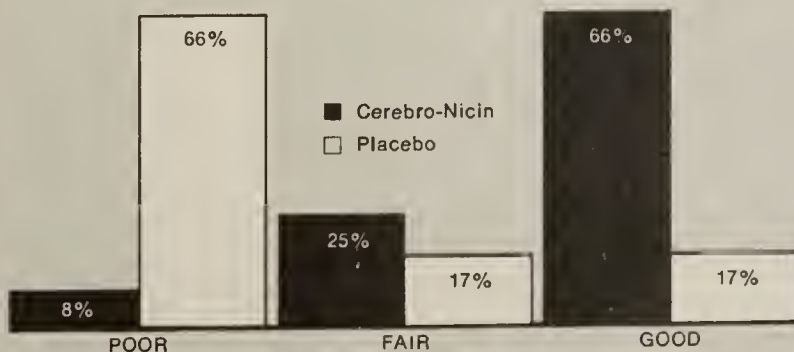
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For the treatment of the aging patient

Cerebro-Nicin[®]
capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN[®] New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylentetrazole, ... 100 mg.
Nicotinic Acid, ... 100 mg.
Ascorbic Acid, ... 100 mg.
Thiamine HCL, ... 25 mg.
1-Glutamic Acid, ... 50 mg.
Niacinamide, ... 5 mg.
Riboflavin, ... 2 mg.
Pyridoxine, ... 3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylentetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.



Write for literature and samples...

BROWN

THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Write for Product Catalog



decision:

Loridine® I.M.

Cephaloridine

1.5 to 3 Gm. daily
successfully treats many
moderately severe
infections*

- bactericidal action in vitro against susceptible organisms causing:
 - pneumonia
 - urinary tract infections
 - septicemia
 - abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.



000903



Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

treatment of their physical ills. In most cases he was able to uplift their spirit as well. And, indeed, he did uplift the spirit of everyone he encountered in his daily rounds at the hospital, on the street, and in his home with a ready witticism, a careless wave of the hand, or his characteristic greeting: 'Peace'."

As the long cortege of motor cars drove through the cemetery gate and crept slowly along the serpentine drive, a gentle rain began to fall. It seemed as though nature itself had joined the mourners in their grief and wept a little as the wind sang softly through the trees during the brief service at the final resting place of this great and good man.

Dr. Lechner knew no compromise in the strict observance of his Hippocratic Oath nor in his high standard of personal ethics. He was blessed with a versatility of talents and interests which challenged him to pursue excellence not only in his chosen field of medicine but in the world of letters as well. He was equally adept at reading and quoting the classics as in publishing medical papers.

Almost continuously since his first days of practice, Dr. Lechner had one or more jobs in the Erie County Medical Society. All of these assignments were accepted willingly and performed effectively because Dr. Lechner had a deep sense of responsibility to the ideals of his profession in its endeavors to improve the health and alleviate the suffering of his fellow human beings.

Dr. Lechner's primary interest and his greatest contributions to medical organizations were in the difficult area of communication. It was natural, therefore, for him to become editor of *The Stethoscope*, the official publication of the Erie County Medical Society. He served in this capacity from 1947 to 1952, and in 1956 he was honored by his Erie County colleagues when they elected him president of their professional organization.

This same pattern of service was repeated in Dr. Lechner's statewide group, the Pennsylvania Radiological Society. Here also he served in various capacities. For many years he was a member of the Executive Committee, and in 1949 he became editor of this organization's official bulletin. Once again his colleagues in his chosen specialty of radiology elected him president of the Pennsylvania Radiological Society.

Dr. Lechner's earliest service in the vineyard of the Pennsylvania Medical

Society was as a member of its House of Delegates. In 1953 he was appointed to membership on the Officers' Conference Committee, and in 1954 he served as chairman. Dr. Lechner was a speaker at this important statewide conference in 1952 and again in 1955.

Over the years Dr. Lechner authored a number of articles for medical publications. Some were scientific treatises on radiological subjects. Others were concerned with the social, economic, and philosophical aspects of medical practice. His ability to express his well-formulated ideas in lucid and and straight-forward prose became well known.

This talent coupled with his experience in editing medical publications made Dr. Lechner the unanimous choice of the Board of Trustees to succeed the renowned Dr. Walter F. Donaldson as medical editor of PENNSYLVANIA MEDICINE—and what a successor he has been! Dr. Lechner was appointed to this position in 1957 and served with distinction until his death.

One theme recurs again and again in the editorial writing of Dr. Lechner during his thirteen years as medical editor of PENNSYLVANIA MEDICINE, and that is his emphasis on the two basic responsibilities of physicians: their duty to their patients and their obligation to their profession. He considered these responsibilities to be inseparable because he was convinced that neither could be satisfactorily discharged without the other. Both were essential in his view to the highest purposes of a physician's calling.

In 1958, shortly after he was appointed medical editor, Dr. Lechner wrote:

"We remain effective as long as we hold to the principle that care of the patient is our prime purpose...as long as we agree on the fundamentals of that care as set forth in our Principles of Ethics..."

"But the doctor must do more than take the best care of his patients...He must join his colleagues in upholding the principles of right conduct. We must make sure that our profession is not cheapened or degraded."

In his last editorial written shortly before his death, Dr. Lechner—as he had done so many times during the years—returned once again to this theme:

"The highly scientific practice of medicine demands great technical

skill on the part of the practitioner. As a result, he is drawn from his patient's personal psychic problems...Although the patient intellectually recognizes the advantage of technical skill, he still needs a personal physician. We must, therefore, not neglect the whole patient in the name of science..."

"Let us remember that our best agent for concerted action is our medical society. We are, therefore, obligated to partake in its activities and to strengthen its performance. We must also learn to co-operate with other organizations in order to make the best use of our resources."

The highest office within the power of Pennsylvania physicians to give to one of their colleagues is the presidency of the Pennsylvania Medical Society. On September 26, 1968, the House of Delegates honored Dr. Lechner by unanimously electing him as president-elect of the State Society.

He was to be elevated automatically to the presidency at the Society's annual meeting in 1969. However, after serving his year as president-elect, ill health forced him to resign just one day before he would have been installed as president. In accepting his resignation, the House of Delegates with a standing ovation designated him as honorary past-president of the Pennsylvania Medical Society and bestowed upon him "all the customary rights and privileges extended to a past-president of this Society."

This year the ravages of disease made it impossible for Dr. Lechner to attend the annual meeting of the Society. As one of its first actions, the House of Delegates voted to send a message to their friend Carl. This letter—in the form of a scroll personally signed by the members present at the meeting—was the last piece of mail Dr. Lechner was able to read. The message, eloquent in its simplicity, said: "Carl—We miss you."

As with so many of my friends in the medical profession, I didn't see Carl Lechner very often—perhaps ten or twelve times a year. The true quality of a human relationship, however, is not measured by the frequency with which people get together. Rather it is measured by the mutuality of interest and understanding which binds them together and by the ability of each to contribute to the happiness and well-being of the other. Judged by

(Continued on Page 14.)

PMS Questions FDA News Releases

The State Society has criticized sharply the Food and Drug Administration for the manner in which it releases public information when the FDA questions about the continued use of a specific drug but no easy way to prevent over-reaction by the public is apparent.

The incident that sparked the PMS action was the FDA announcement that tolbutamide had been judged to be of little or no value in the treatment of diabetes.

The reaction of thousands of patients on tolbutamide was predictable and swift. Worried diabetics jammed phone lines of physicians that had prescribed the drug. The patient anguish and lost medical man hours was the basis of the Pennsylvania Medical Society complaint to the FDA. The PMS said that it had no evidence to cause it to quarrel with the FDA decision but that there was much evidence that the manner in which the FDA announcements are made have a potential for patient harm as great or greater than would be caused by continued reliance on the drug that the FDA was attempting to restrict.

Then on the heels of the tolbutamide announcement came the FDA announcement that it had asked the manufacturers of the sequential oral contraceptives C-Quens (®Lilly) and Provest (®Upjohn) to discontinue their manufacture on the basis that some female beagle dogs developed benign breast nodules. Again, the reaction of patients taking the two contraceptives in question was swift and predictable.

The PMS complaint to the FDA has resulted in some action. Meetings have been scheduled to discuss how the profession might be alerted to FDA decisions prior to public announcement of these decisions so that physicians might have an opportunity to contact their more excitable patients

and prevent possible hysteria when the public announcement is made.

Laudable as this goal is, it probably is impossible. At least it has been tried in the past and it has failed. Previous notification to physicians about an impending FDA decision has resulted in some physicians leaking the information to local newsmen where the potential and actual distortion is far, far greater than that which occurs when the FDA makes

the announcement itself in Washington to the seasoned press corps there.

Meanwhile, it is majority medical opinion that physicians prescribing oral contraceptives should switch from the sequential type because they no longer are being made.

As for tolbutamide, the AMA has suggested that diet to control the mild type of diabetes in which tolbutamide has been used should be the first recourse. **DANE S. WERT**

Food, Drug Commissioner Edwards Clarifies Tolbutamide Issue

Commissioner Charles D. Edwards of the Food and Drug Administration (FDA) has issued a statement regarding tolbutamide (Orinase®, Upjohn) stating that the FDA does not endorse the implication that the oral anti-diabetic agent is a cause of heart disease.

His statement followed release to the press of a study by the University Group Diabetes Program (UGDP) which indicated a possible link between use of the agent and heart disease.

Dr. Edwards said, "The FDA has no thought of any action beyond informing physicians of the results of the university group study and suggesting appropriate label changes. There has been no thought of removing the drug from the market. The implication that Orinase causes heart disease did not originate with the FDA and is not supported by them."

William N. Hubbard, Jr., M.D., vice-president and general manager of Upjohn's pharmaceutical division, said, "It is also important to note that the American Medical Association's recent comment on the UGDP Study states that insulin 'was no better than diet alone, except in controlling blood sugar.' The effectiveness of Orinase

in lowering blood sugar in selected diabetics has never been questioned.

"There is no question that diet alone is the most desirable treatment if it can adequately control diabetes. The choice between oral agents and insulin where dietary control fails is the professional responsibility of the physician in the particular case of each individual patient. This judgment cannot be based on less than all available knowledge about the individual patient.

"Taken together, the FDA, AMA and ADA statements should help considerably in allaying the fears of a diabetic population which has been disturbed by recent news reports of increased cardiovascular disease in tolbutamide-treated patients."

Radiology Group Schedules Seminar

Pneumoconiosis, generally incurable in the advanced state, is the subject of five week-end seminars in mining areas sponsored by the American Board of Radiology. In Pennsylvania the seminar will be held at the Pittsburgh Hilton Hotel, Pittsburgh on January 16-17, 1971.

To comply with new coal mine safety laws all underground miners, and their disabled dependents must be x-rayed within the next eleven months. The seminar is designed to provide physicians with a review of the radiographic findings and an intensive session in the use of the staging system.

Participation of physicians, whether radiologists or not, is encouraged in an effort to stimulate interest in the treatment of pneumoconiosis.

State Birth, Death Rates Decline

Figures released by the Pennsylvania Department of Health showed that both the birth and death rates have continued to decline in 1969. The report indicated however, that there has been a 6 per cent increase in illegitimate births in the period.

state were heart disease, cancer and cerebrovascular disease. There has been a slight decrease in the death rate caused by heart disease and an increase in cancer by 20.7 per cent since 1950, the report indicated. These diseases, taken together, accounted for 70 per cent of the total resident deaths in the state in 1969.

The leading causes of death in the

Medical College Of Pa. To Receive Honor

Clifford H. Keene, M.D., of San Francisco, Calif., the chief executive officer of the Kaiser Foundation Medical Care Program and president of Kaiser Foundation Health Plan, Inc., will be the principal speaker at the Medical College of Pennsylvania January 7, 1971.

Dr. Keene will present an in-depth study of the Kaiser-Permanente Health Plan concept which has demonstrated the possibility of having a self-sustaining, private, organized medical care system within a free enterprise system.

The Medical College of Pennsylvania is being honored at a banquet on this evening by the Newcomen Society in North America for its role in the education of women for medicine.

The Newcomen Society is a chartered, non-profit, organization created for the study of business, industrial and institutional history and achievement.



PRESENT at the Fourth Annual J. Herbert Nagler Memorial Symposium of the Philadelphia Academy of General Practice recently were (seated from left): Arnold S. Kessler, Esq., who spoke on malpractice; Robert Hale, M.D., president, Pennsylvania Academy of General Practice and Alfred Kalodner, M.D., who spoke on abortion. Standing left to right are Joseph H. Simon, M.D., vice-president of the Philadelphia Academy and program chairman; Milton Perloff, M.D., president of the Philadelphia Academy; Gordon Bendersky, M.D., speaker on diabetes; Bernard B. Zamostein, M.D., past president of the Philadelphia Academy and Frank Sullivan, president, Philadelphia Federation of Teachers, speaker on doctors and unions. Topic for this year's symposium was "Controversial Issues in Medicine."

In Memoriam: Carl B. Lechner, M.D.

(Continued from Page 12.)

these criteria, Carl was one of my best friends.

Since we lived almost three hundred miles apart, it was not my privilege to know Carl's family except for his wife Dolores, who usually accompanied him to medical conventions and conferences. I first met Carl's three sons, Carl, Jr., Richard and Mark, and his daughter, Brenda, when I was in Erie to attend his funeral.

I did not need to know all the members of Carl's family over the years to realize that he was a devoted husband and father. Love is a mysterious emotion. It is often revealed most when it is declared least.

Carl didn't talk much about his family, but when he did there was a light in his eyes and faint glow to his smile that spoke with a language more eloquent than words of the tender affection he had for his children and their mother. When love of family is deep and abiding—as it was in this case—it is readily apparent even though expressed in that delightfully casual manner which was the hallmark of Carl Lechner. One need not see the evidence or hear the testimony to know what Carl's family meant to him and what he, in turn, meant to each of them.

Dr. Lechner was a remarkably self-sufficient person. He seemed to have an

inexhaustible well-spring of those qualities which enable one to live through both good times and bad with unwavering equanimity. Much of this was due, I am sure, to his Christian faith. Whatever the reason, this tranquility of spirit enhanced Carl's ability to serve as a haven of refuge for Dolores and their children in time of trouble.

During the summer of 1969 the quiet courage of Dr. Lechner met its most severe test when he realized that he had an illness from which he would not recover but even this burden did not destroy his characteristic serenity or diminish his zest for life. However, in the hour of his greatest need—during the dark days between his first and second operation—he turned for help and comfort to those he loved the best, his wife and children. How completely they responded is revealed in these words which Carl wrote to a close friend a few days after his first operation:

"I dropped a bit in my own estimation when I realized that I did not have as great a store of emotional and spiritual resources as I had secretly thought. A remarkable help has been the calm, steady, and admirable support of my children. Dolores, as you must know, has been a tower of strength and an indispensable prop."

It is difficult to do justice to the life of Carl Lechner because words do

not seem able to capture the essence of his character and spirit. There was about Carl a quality of love for his fellowman, a level of reverence for his God, and a capacity to experience adversity without bitterness or complaint which only a few of us are able to achieve.

I never saw Carl Lechner angry, and I never heard him really downgrade anybody. He rarely criticized and—when he did—his criticism was wrapped in a quip and uttered with such a twinkle in his eye that there was no sting. Carl accepted human frailty with compassion. He seemed to realize and to remember always that there was some merit in every human being—even the contemptible.

Dr. Lechner was a great man. His greatness, however, was not the triumphant greatness of a military hero nor the ceremonial greatness of a political leader nor the spectacular greatness of the first man to walk on the moon. His was the unadorned greatness of a humble man who lived each day of his life close to the way it should be lived.

Above all else, Carl Lechner was kind. If every person for whom he did some act of kindness should one day bring a single blossom to his grave, Carl would sleep that night beneath a wilderness of flowers.

LESTER H. PERRY

First Patients Enter Hershey Medical Center

The Milton S. Hershey Medical Center of the Pennsylvania State University opened October 14, 1970. For all of its unique facilities and fresh concepts in the provision of medical care, education and research it is unique also in being the first new university hospital to open in this state in this century, and the first located outside of Philadelphia or Pittsburgh.

Among the medical center's features are totally automated service areas, such as laboratories, laundry, billing and accounting and maintenance. Personal patient/medical staff relations, however, will be maintained.

Great steps have been taken to insure patient/hospital economy. An ambulant wing provides minimal-care patients with a more economical stay while they undergo testing and diagnosis. These ambulant area rooms are designed after the pattern of standard motel rooms and are about 60 per cent of the normal room cost. The patient gets his own meals in the cafeteria or snack shop rather than in his room.

With very few exceptions the hospital consists of single rooms equipped with private bathroom, electric bed bedstand, color TV and wall to wall carpeting. Despite the luxury, the hospital rooms are at a competitive cost with room costs in other hospitals in the area, that is about \$49 per day.

Each floor includes a teaching area for medical students. It includes a seminar room, charting area for students, and teaching laboratories. This section also has a teaching apartment which enables personnel to work with patients who will require care after their release from the hospital. Dietitians, physical therapists and occupational therapists can work with patients in an environment that bridges the gap between the hospital room and the home. At night the bedroom area of these apartments is used by the house staff on night call.

The pharmacy/central service area is also a rather unique administrative concept merging the processing of all requests for drugs, supplies, linens and general equipment in one place.

All aspects of the patient care service in the new hospital are focused toward the provision of a complete range of medical care while retaining an emphasis on the importance of the individual.

Medical Of Pa. Names New President

Irving H. Leopold, M.D., of New York, N. Y., has been named president of the Medical College of Pennsylvania effective July 1, 1971. Mrs. Paul R. Kaiser, chairman of the board of corporators, has announced.

Dr. Leopold succeeds Glen R. Leymaster, M.D., who left the Medical College to become the director of undergraduate medical education of the American Medical Association.

A prominent ophthalmologist, Dr. Leopold has been chairman and professor of the department of ophthalmology at the Mount Sinai School of Medicine of the City University of New York since 1965, and has been affiliated with Columbia University College of Physicians and Surgeons. He has been a consultant to the National Institutes of Health from 1952-70 and a consultant with the Food and Drug Administration, De-

partment of Health, Education, and Welfare during 1963-64. An author of 251 publications, he has served as editor-in-chief of *Survey of Ophthalmology* from 1958-62.

Currently Dr. Leopold is vice-president of the National Society for the Prevention of Blindness and a member of the AMA's council on drugs and and joint committee for stroke facilities.

Jefferson Expands Short Term Unit

A little over a year ago Thomas Jefferson University Hospital opened a Short Procedure Unit, a unit for short operative procedures that require no more than eight hours of time in the hospital for completion.

The unit is now being expanded from four to fifteen beds operating from 8 a.m. to 11 p.m. to accommodate patients with early afternoon surgery.

This procedure has lowered the patient cost by an estimated 35 to 50 per cent, because there is no longer need for a regular room or board.

Charles W. Semish III, M.D., the originator of the plan, feels that an estimated 5 per cent of the hospital's patients could actually be treated in this type of unit.

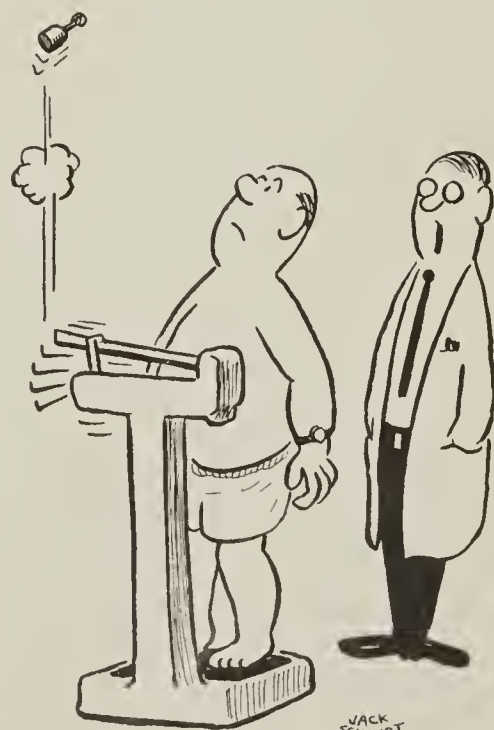
Smoking, Health Week January 10-16, 1971

January 10-16, 1971 has been declared as Education Week on Smoking and Health in Pennsylvania by former Governor Raymond P. Shafer.

The goal of this week is to bring all citizens to an awareness of the harmful effects of smoking on health. Five regional luncheons will be open to school students in Erie, Lancaster, Philadelphia, Pittsburgh and Scranton as part of the educational effort of the Pennsylvania Committee on Smoking and the Health of Youth.

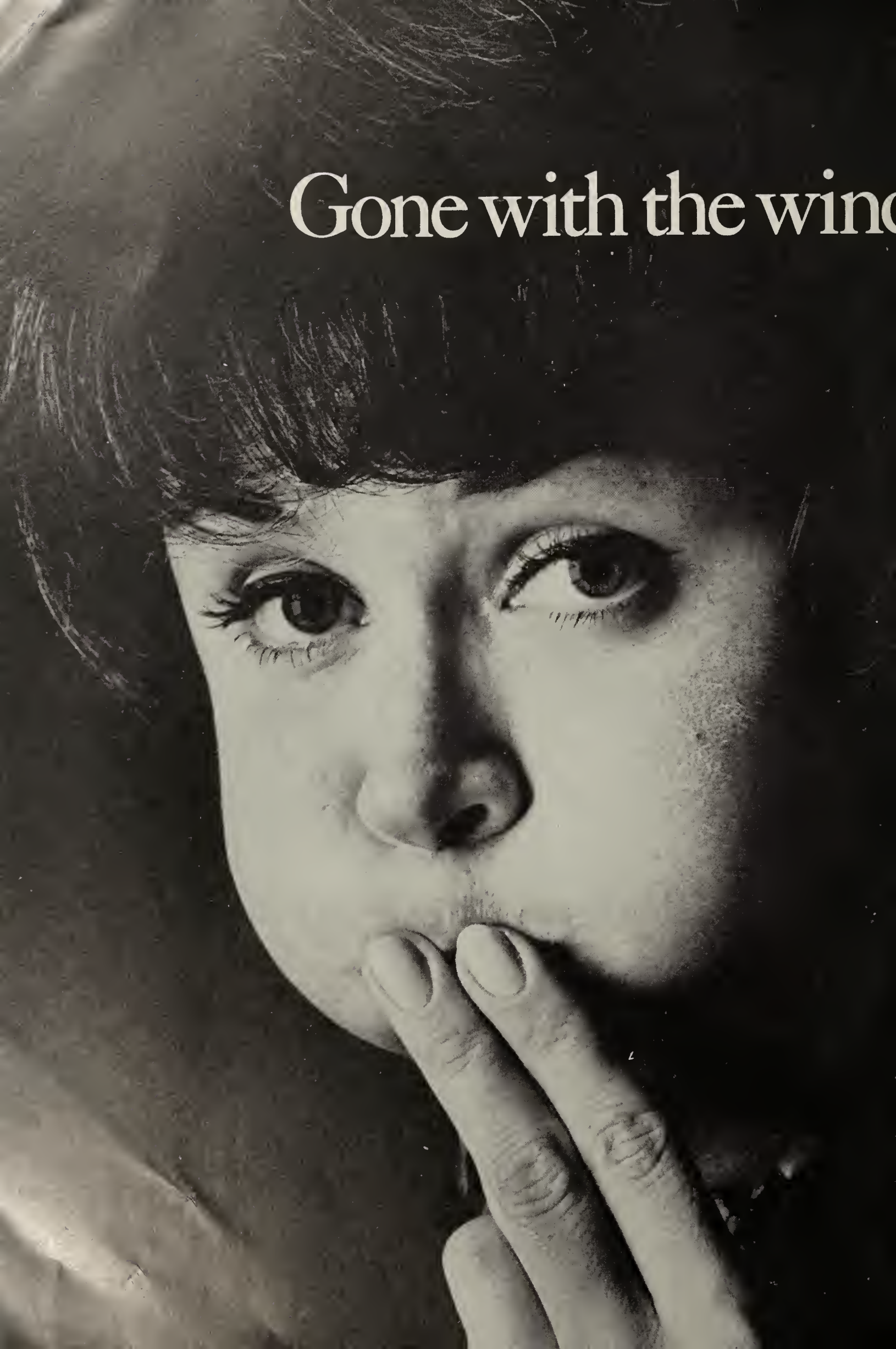
Clinic Association Elects Dr. Buchert

The American Association of Medical Clinics named Walter I. Buchert, M.D., Danville, president-elect of the organization at its annual meeting in San Francisco. The association, which consists of 250 clinics, represents 10,000 physicians providing medical care. Dr. Buchert, who is the medical director of the Geisinger Medical Center, will also serve on the association's board of trustees and executive council. During his term as president-elect his duties will include the planning of the program and arrangements for the 1971 annual meeting.



THAT DOES IT!

Gone with the wind



The gas/acid group of disorders

“The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and ‘gas.’ The two often occur together.”*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in:
gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifothingic/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slinger, A.: Med. Times 94:150 (Feb.) 1966.

Announcing the “Antgasid”

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

one dose does both: frees captured gas...neutralizes free acid

The Doctor

One of the doctor's most important roles is in education.

For his patients, the physician provides the facts, supplies the rationale, triggers the action for life-saving health practices. To his students, he passes on his knowledge and the benefits of his clinical experience. With his colleagues, he shares new information and concepts.

Assisting the doctor in his teaching role is

a major function of our professional education program. Through medical conferences, films, exhibits, pamphlets, monographs and other publications, we provide him with the most important and current information on cancer.

If, as Henry Brooks Adams speculated, "A teacher affects eternity; he can never tell where his influence stops", the outlook is optimistic.





**“Most often it’s my stomach,
but I get headaches too.
My muscles hurt and I’m fidgety
and sometimes I cry?”**

**Somatic symptoms and concerns
caused by anxiety respond
particularly well to **Sinequan®****
DOXEPIN HCl

(Please see last page for full adverse reactions, contraindications, warnings and precautions.)

“Everything
I do is half
done.
I’m restless,
nervous, tired
all the time
and always
nagging.”

Anxiety and
lack of energy
respond
particularly
well to
Sinequan
DOXEPIN HCl



Marked antianxiety action . . .

The antianxiety effect of Sinequan (doxepin HCl) was compared to that of either diazepam or chlordiazepoxide in ten double-blind studies^{1,2} of 422 patients with psychoneurotic anxiety. An analysis of the symptom rating scales revealed that Sinequan was unsurpassed by the two tranquilizers in treating a broad range of anxious symptomatology.

Global evaluation of the double-blind studies also expressed the comparative effectiveness of Sinequan:

SINEQUAN VS. CHLORDIAZEPOXIDE IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	CHLORDIAZEPOXIDE
TOTAL NO. OF PATIENTS	77	72
NUMBER IMPROVED	64	56
MARKED	21	7
MODERATE	27	23
SLIGHT	16	26
% IMPROVED	83%	78%

SINEQUAN VS. DIAZEPAM IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	DIAZEPAM	PLACEBO
TOTAL NO. OF PATIENTS	118	102	48
NUMBER IMPROVED	100	75	33
MARKED	47	34	12
MODERATE	29	29	11
SLIGHT	24	12	10
% IMPROVED	85%	74%	69%

Overall evaluations¹ of patients treated with Sinequan revealed that:

- 84% of 263 patients with symptoms of anxiety showed marked, moderate, or slight improvement
- 87% of 40 patients with symptoms of anxiety accompanying organic disease showed marked, moderate, or slight improvement
- 83% of 142 patients with symptoms of anxiety and depression showed marked, moderate, or slight improvement.

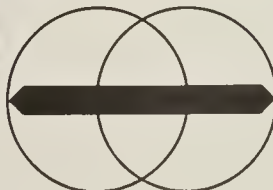
. . . and significant antidepressant activity

Sinequan[®]

DOXEPIN HCl



Starting dosage:
25 mg. t.i.d. for mild
to moderate anxiety



The tranquilizer that is
an antidepressant.
The antidepressant that
is a tranquilizer.

"In a double-blind and placebo-controlled study of doxepin and diazepam in therapy for anxiety superimposed on underlying gastrointestinal disease in 60 patients, doxepin appeared comparable to diazepam in reducing anxiety."

Kasich, A. M.: Psychosomatics Supplement 10:18, May-June, 1969.

(Please see last page for full adverse reactions, contraindications, warnings and precautions.)



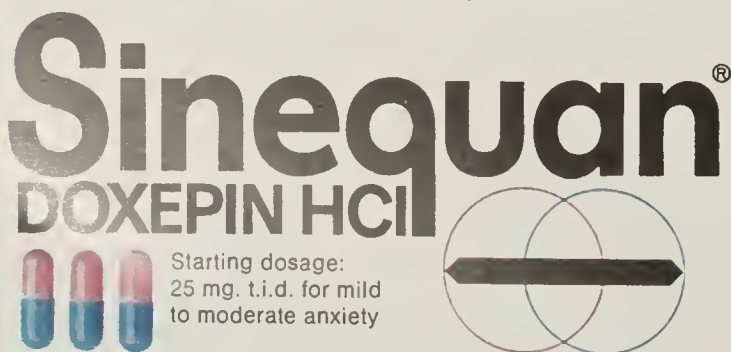
Analysis of standard symptoms rating scales¹ proved the effectiveness of Sinequan (doxepin HCl) in decreasing the intensity and incidence of the most prevalent psychoneurotic symptoms:

Symptom	Improvement with Sinequan
Anxious Mood	74% (59 of 80 patients ^a)
Fears	73% (48 of 66 patients ^a)
Difficulty in decision-making	63% (12 of 19 patients ^b)
Tension	79% (63 of 80 patients ^a)
Depressed Mood	72% (50 of 69 patients ^a)
Loss of interest	73% (11 of 15 patients ^c)
Social Withdrawal	62% (13 of 21 patients ^b)
Somatic Symptoms (General)	76% (31 of 41 patients ^a)
Respiratory Symptoms	83% (19 of 23 patients ^a)
Gastrointestinal Symptoms	77% (54 of 70 patients ^a)
Cardiovascular Symptoms	67% (14 of 21 patients ^a)
Insomnia	73% (53 of 73 patients ^a)

Rating scales used for symptom evaluation

- a. Hamilton Anxiety Scale (Modified)
b. Wittenborn Symptom Rating Scale
c. Anxiety Check List

Effective control of anxiety's most prevalent psychic and somatic symptoms... relief of underlying depression



Sinequan (doxepin·HCl) Capsules

Description. Sinequan (doxepin·HCl) is a new dibenzoxepin psychotherapeutic agent with marked antianxiety and significant antidepressant activity.

Chemistry. Sinequan (doxepin·HCl) is a dibenzoxepin derivative and is the first of a new family of psychotherapeutic agents. Specifically, it is an isomeric mixture of N,N-Dimethyl-dibenz(b,e)-oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.

Indications. In a carefully designed series of controlled studies, Sinequan (doxepin·HCl) has been shown to have marked antianxiety and significant antidepressant activity. Sinequan (doxepin·HCl) is recommended for the treatment of:

- (1) Patients with psychoneurotic anxiety and/or depressive reactions.
- (2) Mixed symptoms of anxiety and depression.
- (3) Alcoholic patients with anxiety and/or depression.
- (4) Anxiety associated with organic disease.
- (5) Psychotic depressive disorders including involutional depression and manic-depressive reactions.

The target symptoms of psychoneurosis that respond particularly well to Sinequan (doxepin·HCl) include anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

In those patients in whom anxiety masks the depressive state, Sinequan (doxepin·HCl) is of particular value since it exerts a potent antidepressant effect as well as anti-anxiety activity.

Patients who have failed to respond to other antianxiety or antidepressant drugs may benefit from treatment with Sinequan (doxepin·HCl).

Clinical experience has shown that Sinequan (doxepin·HCl) is safe and well tolerated even in the elderly patient.

In a large series of patients systematically observed for withdrawal symptoms, none were reported. This is consistent with the virtual absence of euphoria as a side effect and the lack of addiction potential characteristic of this type of chemical compound.

Contraindications. Sinequan (doxepin·HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin·HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin·HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin·HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin·HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of the possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin·HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin·HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin·HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin·HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin·HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

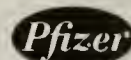
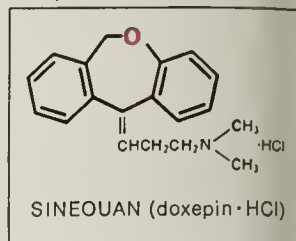
In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin·HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

References: 1. Data on File, Medical Research Laboratories, Pfizer Pharmaceuticals, Pfizer Inc., Groton, Conn.
2. Pitts, N.E.: Psychosomatics 10:164, May-June, 1969.



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**PUBLISHED TO REPLACE A PREVIOUS
ADVERTISEMENT WHICH THE FOOD AND DRUG
ADMINISTRATION CONSIDERED MISLEADING**

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as :

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus*. GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*.

Injectable **Garamycin**[®] brand of **gentamicin sulfate** **injection**



Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa*, *Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those

in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

SCHERING CORPORATION, UNION, NEW JERSEY 07083

Concerning the Ethical Storage and Retrieval of Privileged Medical Information in Computers

Issued by the Judicial Council of the Pennsylvania Medical Society

August 11, 1970

(Publication authorized by the House of Delegates, October 7, 1970)

1. There is no violation of medical ethics as presently constituted, by the release of a patient's medical records to a computer bank if such release
- (a) is not by name but by code identifying the patient, the doctor, and the hospital, clinic, diagnostic and treatment center, or other agency maintaining confidential, closed files or clinical data.
 - (b) is designed to amass clinical information, statistical evaluation and comparison, and analytical advice to be used for the benefit of people generally, for the proper care of the patient by his physician, and for the guidance and rating of hospital management (both lay and professional)
 - (c) is guarded and protected against non-authorized use and frivolous retrieval of banked information.

Comment: We are advised that anonymity of patient has been guaranteed by the computer banks now in business: that the identification of doctors and institutions is coded. Few if any individual doctors will have use for, or supply information to such storage centers.

We are advised that the accreditation authorities have recommended, or required, that hospitals subscribe to such computer services as in Ann Arbor (PAS) and Pittsburgh (HUP).

If the computer concept or "idea" becomes useful and important, it can only serve to eliminate unnecessary and "battery" testing; to reduce hospitalization for study; and to encourage establishment of out-patient diagnostic and treatment centers and groups. We believe this to be the trend of the future.

2. The same ethical principles apply to the use of computerized medical information as apply to any other medical record.
3. Of necessity, a computer bank must be used for retrieval of information as well as for storage. No physician shall be deemed in violation of ethical conduct, nor should he be liable at law, if he uses clinical

information supplied by a computer bank, and obtained without subterfuge, in the care of patients, for the improvement of his knowledge, and the advancement of and research in medical practice.

4. The costs to the physician of retrieval of information from a computer bank are rightly part of the costs of his office overhead, and may be included with his professional charges to patient or patients.

Page 1

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POD Form 3326 May 1968

Commissioner Analyzes Blue Cross Rate Increase

After analyzing the present problems of health care delivery, with respect to the cost to the public of Blue Cross and Blue Shield prepaid coverage, Pennsylvania Insurance Commissioner George F. Reed announced this summer the approval of rate adjustments by Blue Cross of Greater Philadelphia. The rate increase amounted to 25.3 per cent.

The rate adjustment sought by Blue Cross of Greater Philadelphia, was for the area encompassing Bucks, Chester, Delaware, Montgomery and Philadelphia counties, and is expected to provide an estimated annual revenue of \$32,436,000. It was the largest adjustment ever submitted to the Pennsylvania Insurance Department.

In granting the rate adjustment, Commissioner Reed in his decision analyzed factors affecting health care costs. The reason for such rapidly spiraling high cost coverage may be attributed in part to the federal government's Medicare program which was introduced on July 1, 1966, his decision indicated. The Medicare program has influenced the cost of health care in two ways. First, it provided for hospitals to be reimbursed on an open-end contract basis, which assured the hospital of prompt payment. With this plan in operation hospitals were in an opportune position to increase their staff, raise salaries, modernize and begin expansion projects. For many hospitals these improvements were overdue and necessary for efficient functioning.

Second, since the Medicare program's initiation, the public has become increasingly health conscious. More people can afford medical care and demand quality health care.

This is not the only contributing factor, he said. Inflation has had a profound impact, which, when coupled with the demand for quality health care, has placed increasing demands upon an inadequate supply of medical doctors.

Although hospitals have not been financially able to cope with today's economy, their problems become intensified by the fact that the hospital board, charged with the responsibility of administering care, does not have complete control over the medical staff's responsiveness to demands for economy and efficiency.

The rate increase approved for Blue Cross was for continued maintenance of coverage, that is to insure that a

payment of 95 cents on each dollar is returned to subscribers in the form of health care payments. Blue Cross must also exercise its influence in assuring that health care delivery programs are operating economically and efficiently. The Pennsylvania Insurance Department has taken steps to insure that the Blue Cross plans in Pennsylvania combat the rising cost of health care.

Blue Cross of Greater Philadelphia, in particular, has been subject to direction by the department, which, for example, disapproved the original plan proposal until it was amended to include incentives to encourage hospitals to control their costs. "As finally approved the contract included the following:

- a. A requirement that a hospital apply to Blue Cross subscribers the same plan for utilization review required under Medicare.
- b. An inducement to the hospitals to participate voluntarily in the Blue Cross Pre-Admission Testing Program, which is aimed at reducing the use of expensive in-patient hospital facilities when not necessary.
- c. Reimbursement on a specified basis to hospitals for programs voluntarily undertaken to employ modern management techniques including the retention of expert consultants, for the measurement and control of the effectiveness of hospital expenditures.
- d. An offer of increased reimbursement to a hospital for an experiment which it voluntarily undertakes in order to achieve greater efficiency and economy in the proving of its services without adversely affecting the quality of its patient care.
- e. A 3 per cent reduction in reimbursement to those hospitals failing to receive accreditation by the Joint Committee on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association, thereby seeking to guarantee that all hospitals meet recognized standard for patient care.
- f. A substantial reduction in reimbursement with regard to any replacement or expansion of a hospital's facilities which is constructed at a cost of more than \$250,000 without obtaining the prior approval of the Philadelphia Hospital Survey Committee, thereby seeking to eliminate unnecessary demand for medical and technical personnel and the cost to the community of creating,

operating, and maintaining unnecessary facilities."

It was proposed that representatives of each of the Blue Cross plans in Pennsylvania and Pennsylvania Blue Shield meet "in order to explore ways of achieving consistency of approach... to encourage economy and efficiency in the health care delivery system." It was also proposed that "the problem of duplicate payments for services rendered" be included on this meeting agenda. Duplicate payment is a definite possibility, and even the seemingly insignificant duplication must be eliminated.

Even these steps will not totally eliminate the problems. Some patients insist upon unnecessary hospitalization, some doctors prefer the convenience of the hospital to more out of the way facilities. Hospital administrators sometimes plan foolishly and purchase expensive, little-to-be-used equipment to keep up their facilities with respect to what other area hospitals have.

Among the various aspects contributing significantly to rising health care costs are poorly planned admissions policies which have patients entering the hospitals late in the week when testing is not to begin until early in the next week. This means inefficient utilization of hospital facilities and added expense to the patient. Despite the efforts of utilization review committees of each hospital and in-patient treatment facilities total elimination of inefficient usage is not always possible. For example, extended care facilities are not always available to patients and so both hospital and patient must bear the expense of having the patient remain in the hospital for what attention he might require.

Recently the number of malpractice claims against hospitals and doctors have put them on the defensive in providing patient care and so there are increased testing and longer stays in the hospitals to try to counteract the questions arising from these claims.

In summing up, Mr. Reed proposed that the national health plans presently under discussion are no solution to the health care problems, that they merely provide a source of funds for health care delivery. An effective plan he said, must be introduced that restructures the present system to eliminate uneconomical and inefficient aspects.



Richard H. Helfant, M.D., Philadelphia was recently appointed chief of the division of cardiology at the Presbyterian-University of the Pennsylvania Medical Center. He will establish a consultation service for the diagnosis and management of cardiac patients with an emphasis being placed on those patients with coronary artery disease. Dr. Helfant, a pioneer in stress procedures, has perfected a catheterization technique which allows the recording of the specialized electrical conduction system of the heart. Using this procedure he can pinpoint areas of heart block and delineate the origin of complex arrhythmias.



DR. HELFANT



DR. STADER

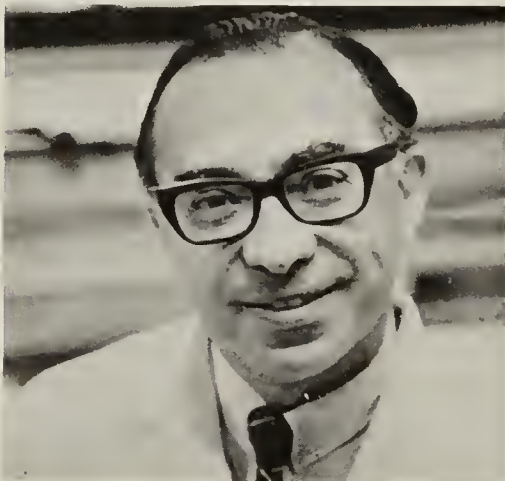
Donald E. Stader, M.D., pathologist and director of laboratories of the Sacred Heart Hospital, Allentown, was elected president of the Pennsylvania Division, American Cancer Society, at the Society's 26th Annual Meeting in Carlisle. Robert C. Eyerly, M.D., Danville, was elected second vice-president. Ralph D. Bacon, M.D., Erie, and Harry Winslow, M.D., Meadville, were elected to the board of directors, as was Roland A. Loeb, M.D., Lancaster, who edits "Cancer Forum" for PENNSYLVANIA MEDICINE. William Tyler Douglass, Jr., M.D., Harrisburg, was named recipient of the Sword of Hope Award, the highest individual honor given to a volunteer of the American Cancer Society.

Jonathan E. Rhoads, M.D., professor of surgery at the University of Pennsylvania School of Medicine, was recently elected president-elect of the American College of Surgeons at the group's fifty-sixth annual Clinical Congress in Chicago. Dr. Rhoads is also president of the American Cancer Society and of the Philadelphia County Medical Society.

Charles Duttonhofer, M.D., Churchtown, recently celebrated his seventy-sixth birthday and some fifty years in

practice. He is a past president of the Lancaster County Medical Society. Last year he received fifty-year plaques from the PMS and Jefferson Medical College's alumni association. Also serving for more than fifty years is John H. West, M.D., Easton, who at eighty-four is going into retirement. He has been a practicing physician in Easton for fifty-six years, carrying on a tradition which dates back to 1850, when his father established a practice in Easton.

Victor P. Satinsky, M.D., a Hahnemann professor of surgery, has been appointed associate dean for human research development at the school. Dr. Satinsky, who has published numerous scientific works, is recognized for his contribution to research in heart surgery and in education programs for high school, college and medical students and teachers.



DR. FARBER

Emmanuel Farber, M.D., a specialist in the link between environmental chemicals and cancer, has joined the staff of Temple University Health Sciences Center. Dr. Farber, who holds a lifetime research professorship from the American Cancer Society, will serve Temple as professor of pathology and biochemistry, and senior investigator at the Fels Research Institute. He was previously professor and chairman of the department of pathology at the University of Pittsburgh.

Dr. Farber plans to set up a training program for research in the field of cancer and other diseases that may be caused by insecticides, preservatives and other environmental chemicals.

Presently, Dr. Farber has a four member research team that has joined him in studying the chemical changes in tissue during the development of cancer.

In recent ceremonies at Valley Forge Hospital, Paul A. Bowers, M.D., received the outstanding civilian service medal for his work as consultant in obstetrics and gynecology in the department of the Army.

Three new departments within Lankenau Hospital's division of medicine have been created and department chiefs named. They are a department of cardiopulmonary diseases, headed by Leon Cudkowicz, M.D., Haverford; a department of hematology headed by Thomas G. Gabuzda, M.D., Bala Cynwyd; and the department of gastroenterology, headed by Franz Goldstein, M.D., of Narberth.

Turner C. Johnson, M.D., a North Philadelphia physician, has been named director of Temple University's Community Mental Health Center. Dr. Johnson will be concerned not only with diagnosis and treatment of chronic mental illness but also will be involved with preventive aspects of mental health. As the center is currently set up, there is a twenty-four hour emergency service for persons needing part time or full time clinical care.

Charles E. Myers, M.D., Kingston, and Katherine B. Sturgis, M.D., Philadelphia, recently were awarded environmental health awards by the Pennsylvania Department of Health.

Richard D. Hasz, M.D., a family physician, has joined the Hershey Medical Center's faculty as an instructor in family and community medicine. Dr. Hasz's other duties will include conducting pre-employment examinations, on-the-job injury treatment and health maintenance programs for employees.

John J. Dowling Jr., M.D., Gladwyne, was appointed chief of the department of orthopedics at Lankenau Hospital. He succeeds John J. Gartland, M.D., who has become chief of the department of orthopedics at Thomas Jefferson University Hospital.

Charles Burton, M.D., a neurologist, recently joined the faculty of the Temple University School of Medicine as an assistant professor of neurology and neurosurgical research coordinator at the hospital. As one of his projects, Dr. Burton will institute the new technique of tele-thermococulation, which is a method of producing brain lesions to treat metastatic cancer, diabetic retinopathy and intractable pain.



Courage, Loyalty And Integrity

These words, courage, integrity, and loyalty, were spoken by Bishop Alfred M. Watson of the Erie Diocese to eulogize the late Carl B. Lechner, M.D., medical editor of PENNSYLVANIA MEDICINE. Those who knew Carl recognize just how well they aptly described his character. His many professional and community activities over the years served as ample proof that he had, indeed, by his actions revealed all of these attributes of great character. Pain, severe disfigurement and the relentless progression of his fatal illness did not make him a lonely, bitter or despairing man. He faced this final challenge with the same inner strength that served him so well throughout his life. We grieve at his loss but are comforted in the knowledge of the maturity that he gained during his lifetime.

He expressed his love of life through his steadfast dedication to the high standards that he set for himself. His community and professional involvements were a testimony to his high standards. He did not flounder in his endeavors for he was able to forgive and forget and to live in harmony with people who held opposing opinions. Carl's ability to learn from past experience gave him the wisdom to be at peace with himself and others and still effect constructive change.

His personal life was filled with a vigorous desire to be a good husband and father. He was devoted to his gracious wife, Dolores, and their four children—Carl Jr., Dick, Brenda and Mark. In June, while visiting with him in Erie,

he brought us up to date on all of the latest happenings of their offspring. With precious little time yet remaining he could still speak of each of them with delight and great interest in their plans for the future. Later in the day while sitting at the dining room table in his home, it was readily apparent that he and Dolores had succeeded in raising not only intelligent but aware young adults—alert to the changes that were transpiring in the world around them and very much a part of their community.

His devotion to PENNSYLVANIA MEDICINE has been well documented on its editorial pages for the past twelve years. Staff, past and present, as well as those physician members closely associated with him in his Pennsylvania Medical Society activities were afforded a rare opportunity in working with CBL.

Carl's legacy to the future will be through his family, friends, and colleagues. No one who worked with Carl could avoid being influenced by his considerable intellectual talents and his devotion to the progress of the art and science of medicine. His wit and wide ranging interests and knowledge made him a vibrant personality but his character made him an extraordinary human being.

Yes, he is gone—he was not immortal but he lives in the hearts of those who knew and loved him for what he truly was—courageous, loyal, and honest.

David A. Smith, M.D.
Associate Medical Editor

Medicine First

Editor's Note: This message is the last editorial Carl Lechner wrote for PENNSYLVANIA MEDICINE. It is, then, his last will and testament to his fellow physicians. He was editing papers, writing and reading copy for this journal as late as September 27, 1970, when, with great physical effort, he cleared his desk of all pending matters. Those of us who worked with him miss him.

To honor the physician and to respect the profession of medicine create valuable and important assets for society. Since medicine is made up by the association of men it is bound to reflect the defects which arise from human imperfections. To elevate levels of performance we must set standards of excellence which can make each doctor strive to do his best and can stimulate each unit of medical organization to be constantly alert to prevent defection and to stimulate higher levels of conduct and performance.

This is not to be brought about solely by the efforts of physicians and their societies. The honor and respect must arise from the doctor's fellow citizens, although based on the performance of the doctor. There must be adequate rewards if the honor and respect are to be felt as genuine. The doctor's position in society, his conditions of work and study, his living conditions and those of his family as well as his financial compensation must be considered if we are to keep medicine preeminent in the hierarchy of the professions which serve the people.

There does not seem to be any lack of these recognitions

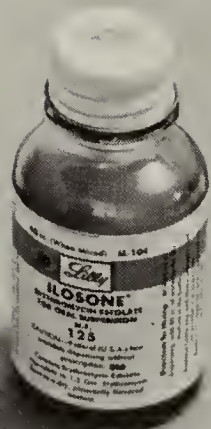
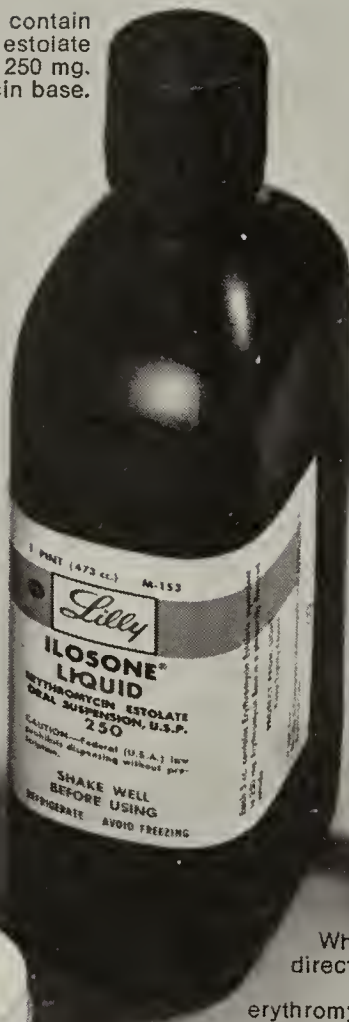
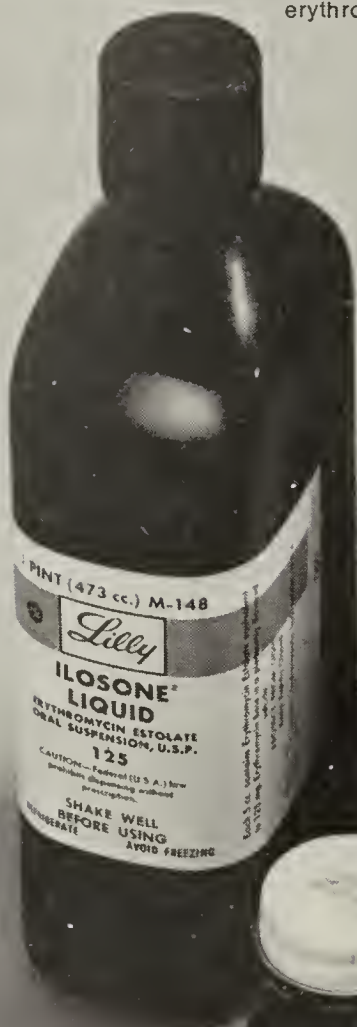
for the individual practitioner. His patients honor and respect him. But, paradoxically, the preeminence of his profession among those of modern society is less secure. Most of us will agree that people look upon our profession of medicine with less regard than we might like.

But we need the highest regard of our fellow citizens if we are to attract the best students, if we are to be allowed the best opportunities for research, the best equipment and conditions for practice, the highest cooperation from related professions, and the like. Moreover, the greatest degree of cooperation from patients, their families, from labor and management and from the many third parties now concerned with health care, depends greatly upon the way the science and practice of medicine are viewed by the public.

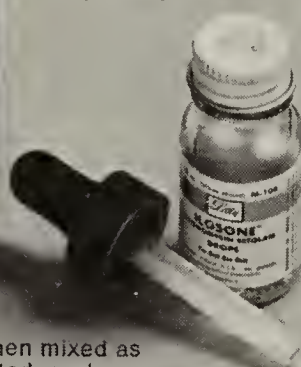
A recent discussion with a physician who had had an opportunity to study the conditions of medicine in Russia is pertinent. In spite of the fact that the U.S.S.R. gives much time and resources to the production of physicians and to the delivery of health and medical care, the physi-

(Continued on Page 31.)

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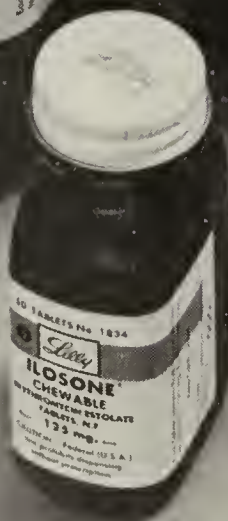


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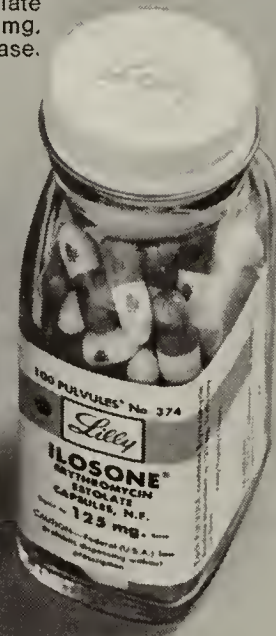


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cian and his profession do not occupy the high place which is essential if doctors are to do the best for the people. If medicine is regarded as a technical public service, the physician is merely a technician and the care of the patient will be correspondingly diminished.

There are many problems in keeping medicine pre-eminent. Most of these have to do with the education, practice and personal performance of the individual physician. But there are also problems for medical societies, their elected officials and their executive staffs, not to be considered here.

Possibly the major problem for the practitioner is that of public relations. The physician may not, in many cases, put his best foot forward in dealing with the public. His usually excellent college education should fit him well for this task but his later scientific education often seems to nullify his humanistic background. The reform now taking place in medical education should lengthen and strengthen the doctor's background in the humanities, even at the expense of lengthening the premedical period. It would be a tragedy if the richest nation in the world mistakenly deprived its citizens of an educated medical profession in the name of modern science. In keeping medicine eminent let us then maintain a highly educated medical profession.

Another danger before us arises because of the nature of the advances in scientific medicine. The highly scientific practice of our times demands great technical skill on the part of the practitioner. As a result he is drawn away from his patient's personal, psychic problems in order to perform many complex technical procedures. He seems to the patient to be more and more a technician. And, although the patient intellectually recognizes the need and advantage of this, he still needs a personal physician. We must therefore not neglect the whole patient in the name of science if we are to keep our profession preeminent.

Let us remember that our best agent for concerted action is our medical society. We are therefore obligated to partake in its activities and to strengthen its performance. We must also learn to cooperate with other organizations in order to make the best use of our own resources.

There are many additional ways of strengthening our profession and keeping it in first place among the other professions. These will frequently occur to physicians who are aware of their obligations to strengthen the profession and improve performance. All aspects of this problem, selfish as well as altruistic, demand that we keep this in mind for the common good.

CBL

Let George Say It:

Moral Convictions

GEORGE A. ROWLAND, M.D.
Millville

The Pennsylvania Medical Society was served less than well by some delegates at Lancaster when a liberalized position on abortion was rejected. This does not refer to those delegates who honestly believe that abortion is murder and that euthanasia, mercy killing, and total moral degradation will follow diminished restraint. This viewpoint, if truly held, must be respected.

It is those physicians who believe that it is a woman's right to dispose of her own body as seems proper to her who did the damage. It is those who feel that a doctor should not be hampered by legal restrictions in picking the best available method of treatment for each case; those who consider abortion as surgery which should have the same sort of controls that maintain high standards for every other type of surgery in this country; those who recognize the importance of population control and the terrible cost of illegitimacy, forced marriages, and unwanted children, who should be ashamed.

I indict these physicians and myself as well—for I had a voice in that house. At 3:30 Wednesday afternoon,

October 7, a few delegates argued about trifles, as to whether abortions should be restricted to hospitals, but nobody was willing to attack the main issue. Nobody rose to say that doctors maintain a very clean house in other respects and we can trust each other to handle the abortion problem in an honorable, moral, and scientific fashion.

It is very likely that the next year will see either legislation or court action free this problem from its place on the police blotter in this state. It will leave the Pennsylvania Medical Society with an antiquated and ambiguous position. This action has already reinforced the opinion of many students and young doctors that the Society is a bastion of reaction where progress is anathema.

The Washington State Medical Association has faced this problem squarely. The College of Obstetrics and Gynecology and the College of Psychiatry favor removal of restricting legislation. Even the American Medical Association has been more forward looking than this. Moral courage often loses battles. This time it lost by default.

The response of the multitude of friends of Carl B. Lechner making contributions to the Educational and Scientific Trust of the Pennsylvania Medical Society has permitted the establishment of a living memorial to him.

Income from The Carl B. Lechner Memorial Fund will be used for educational purposes including financial assistance to medical and paramedical students, with preference being given to residents of Erie County.

Additional contributions can be made directly to the Educational and Scientific Trust of the Pennsylvania Medical Society, 20 Erford Road, Lemoyne, 17043. Checks should be made payable to the Carl B. Lechner Memorial Fund—E.S.T. All such contributions are tax deductible.

Estrogen Therapy In Atrophic Vaginitis

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and

HOWARD BALIN, M.D.

Philadelphia

OURS IS AN aging population and the trend is especially pronounced among women. Even in this context, however, the familiar term *senile vaginitis* leaves something to be desired; it is neither as broad nor as specific as *atrophic vaginitis*. The latter term encompasses not only age-associated manifestations, but also those relating to surgical or radiologic castration. At the same time it literally designates the essential pathologic state—atrophy of the vaginal epithelium (sometimes extending to sub-epithelial structures) with consequent dysfunction. Whether the surrounding circumstances are chronologic or iatrogenic, the underlying common factor is a reduction in available endogenous estrogen. This may occur during the early climacteric years after the menopause, or in younger women with severe ovarian deficiency.

The patient most frequently presents herself for gynecologic care because of vaginal burning, itching and dyspareunia. Pelvic examination reveals a thin watery discharge from a friable vaginal mucosa devoid of rugae. The latter appears thin, almost transparent, glistening and inflamed, and bleeds with minimal trauma. Not infrequently, areas of shallow ulceration are seen. Vaginal smears prepared for cytochemical evaluation show numerous parabasal cells with a paucity of superficial cornified cells; i.e., poor maturation index.

In addition to the routine gross and cytologic examinations mentioned above,* the magnifying optical system of the colposcope makes possible stereoscopic visualization of the vulva, vagina and cervix at magnifications of ten to twenty times under direct illumination.²⁰ Color colpophotography can provide permanent objective data,

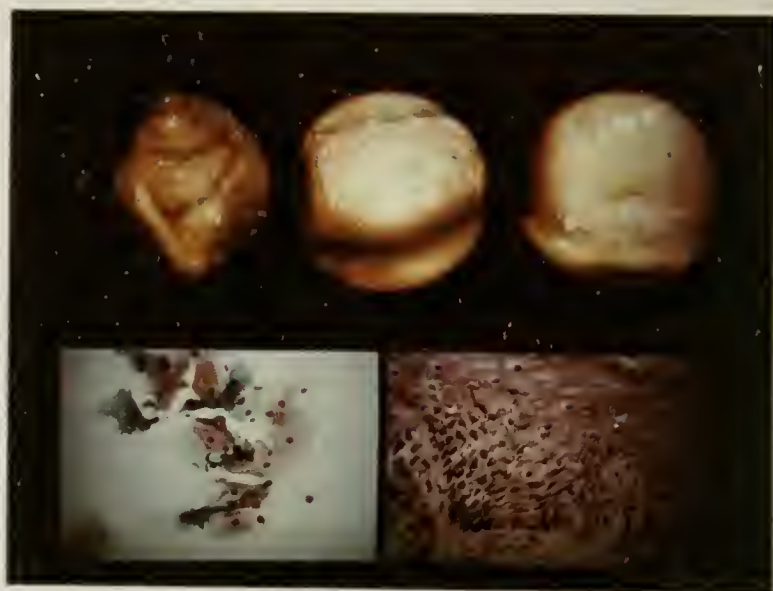
* *Colposcopy and colpophotography have proven a valuable diagnostic adjunct.*



PATIENT L.G.: 57 years old, menopause at age 50; PMH: negative; OB Hx: para 5, gravida 7, ab. 2; atrophic changes; ext. gen., vag., and cvx.; wet smear: neg. trich. and fungi; Pap smear: class I; Dx: postmenopausal atrophic vaginitis.

FIGURE 1A: ABOVE, LEFT—Patient L.G. before treatment.

Left to right: Color colpophotographs of vulva, vagina and cervix; note thinning and micropetechial hemorrhages of vaginal and cervical mucosa. Below, left: Vaginal cytology with numerous parabasal cells. Below, right: Histologic



section from mid-posterior vaginal wall showing thin, atrophic epithelium.

FIGURE 1B: ABOVE RIGHT—Patient L.G. after 4 weeks of treatment (intravaginal application of dienestrol cream). Left to right: Color colpophotographs of vulva, vagina and cervix show restoration of normal mucosal thickness and formation of vaginal rugae. Below, left: Vaginal smear evidencing good estrogenic effects. Below, right: Histologic section showing normal thickness of vaginal mucosa (mid-posterior wall) with superficial hyperkeratosis and acanthosis.

TABLE I. EVALUATION OF CLINICAL RESPONSE

	Excellent	Good	Fair	Poor	Total
Patients on suppository (group A)	21	6	-	1 (4%)	28
Patients on cream (group B)	9	4	2	1 (6%)	16

Excellent = Complete clinical relief of symptoms and lush vaginal mucosa typical of women of childbearing age.

Good = Complete clinical relief of symptoms and good appearance of mucosa (But not appearance as in young women).

Fair = Clinical improvement and improved appearance of mucosa (not the desired end-point).

Poor = Little or no change.

obtained from individual cases, to help discern and document the severity of involvement. Under colposcopic control, vaginal biopsies can be taken to add another diagnostic approach—and also a standard for the evaluation of therapy.

In the years since hormonal treatment has become available to the clinician, the presence of atrophic vaginitis suggests the possibility of some type of estrogen supplementation therapy. As one reviews the literature, the question of therapeutic approach—local versus oral or injectable¹⁸—still remains an unsettled issue.

Materials and Methods

In this study, estrogenic treatment in the form of dienestrol was applied locally (as intravaginal suppository or cream) in the treatment of a group of women with atrophic vaginitis. Forty-four patients are reported on; five others originally in the study are not analyzed as they were lost to follow-up.

Suppositories, each containing 0.7 mg. of dienestrol, were used by 28 patients (group A), while 16 women used a 0.01 per cent dienestrol cream (group B). One applicatorful of the latter delivers approximately the same dose of dienestrol as a single suppository. Each patient followed an identical course of treatment, consisting of a single intravaginal insertion of suppository or cream nightly for two weeks followed by an every-other-night regimen for two weeks.

The study group included 26 private out-patients (16 on cream, 10 on suppository) and 18 in-patients (all on the suppository) treated at a home for the aged. The patients ranged in age from 49 to 92 years; of these, 12 patients were under 60 years; 14

patients, 60 to 69 years; and 18 patients were 70 years and over. In the latter category, 16 patients were residents of the old-age home (where only suppositories were used).

Before starting treatment, all patients were examined; the physical clinical condition of the vulva, vagina and cervix was observed and recorded; cervicovaginal smears were taken for cytochemical* and Papanicolaou** determinations. In addition, wet smears were reviewed to rule out trichomoniasis; candidiasis cultures*** were also taken and reviewed. A positive result on any of these tests excluded the

* A maturation index was performed and recorded primarily on the basis of superficial cells observed.

** Papanicolaou smear classifications: I for 41 patients; II for 2 patients; smear unsatisfactory for one patient.

*** Cultures on Nickerson's medium were checked for candida organisms.

patient from the study. Identical testing was repeated after the first two weeks of treatment; this provided a two-stage assessment of clinical response and cytologic status. In recording maturation indices, a slide rated unsatisfactory (superficial and intermediate cells absent) was assigned a nominal value of 1 per cent superficial cells, to permit statistical analysis of the data and the tabulation of geometric means.

In addition to the 44 statistically analyzed cases, another 4 patients with atrophic vaginitis—2 treated by intra-vaginal application of dienestrol suppositories—were studied not only by the clinical and laboratory procedures described, but also by colposcopic examinations of the vulva, vagina and cervix uteri. Observations were recorded by color colposcopy prior to treatment, after two weeks, and after four weeks of treatment. In all 4 of these patients, vaginal spot biopsies were taken from the mid-posterior vaginal wall, under colposcopic guidance, prior to and after four weeks of treatment. Colposcopic, cytochemical and histologic findings for one of these 4 patients, pre-treatment and post-treatment, are presented in Figures 1A and 1B.

Results

Clinically (in terms of symptomatology and gross visualization) almost all patients responded with some degree of improvement to the dienestrol medication. The vaginal suppository (used in group A) apparently gave slightly better results than the cream (used in group B). Moreover, patients in the former group were older, and presented generally a greater severity

TABLE II. SUB-GROUP MATURATION INDICES

Geometric Means of Superficial Cell Percentages

	UNDER 60				60 TO 69			
	Start	2 wks.	4 wks.	No. Pts.	Start	2 wks.	4 wks.	No. Pts.
Suppos. (group A)	15.3	76.3	56.7	(4)	17.6	74.9	59.6	(7)
Cream (group B)	31.6	67.8	66.0	(8)	14.7	56.7	59.9	(7)
All Pts.	24.8	70.6	62.8	(12)	16.1	65.2	59.7	(14)
	70 AND OVER				ALL AGES			
	Start	2 wks.	4 wks.	No. Pts.	Start	2 wks.	4 wks.	No. Pts.
Suppos. (group A)	18.5	61.7	54.7	(17)	17.8	66.8	56.1	(28)
Cream (group B)	37.0	44.0	1.0	(1)	22.9	61.0	48.7	(16)
All Pts.	19.3	60.5	43.8	(18)	19.5	64.6	53.3	(44)

of involvement prior to treatment. Cytologically, the over-all results of treatment (age-corrected) as shown in Table 2, reveal somewhat greater increases of maturation index in response to the suppository than to the cream, but these differences were not statistically significant.

Cytologic findings at two weeks and at four weeks were analyzed for the 34 patients in the group who had been found, at the start of the study, to have a superficial cell count below 45 per cent. Ten such patients were treated with cream; three of these (30 per cent) never reached the 60 per cent level during the study, four (40 per cent) reached a level above 60 per cent at two weeks and retained that level at four weeks, two (20 per cent) reached above 60 per cent level at two weeks but fell below at four weeks, and one (10 per cent) did not reach 60 per cent at two weeks but did so at four weeks. The other 24 patients with an initial value below 45 per cent were treated with suppository; six of these (25 per cent) never reached the 60 per cent level during the study, seven (29 per cent) reached a level above 60 per cent at two weeks and retained that level at four weeks, eight (33 per cent) reached above 60 per cent level at two weeks but fell below at four weeks, and three (13 per cent) did not reach 60 per cent at two weeks but did so at four weeks.

There were no reported side-effects and no untoward reactions were noted. Both forms of medication seemed to be fully acceptable; however, one patient stated that she had difficulty in using the cream.

Discussion

Several considerations have prompted previous investigators to prefer the intravaginal route for estrogen treatment in atrophic vaginitis. These include patient acceptability and the avoidance of various side effects sometimes ascribed to estrogen given orally or parenterally.^{1,4,17,19} As regards the latter, it has been pointed out that systemic estrogens are rarely, if ever, indicated in patients with localized pathology, because of possible undesirable effects on the endometrium^{4,5} and a tendency to produce breast tenderness and breast cysts.¹⁸ On the other hand, the relative safety of intravaginal estrogen therapy (even over prolonged periods of use)^{1,2} recommended this route as a logical way to restore the vaginal epithelium to its

former physiologic state.³ In addition, Rakoff¹⁷ has reported that, in instances of atrophic vaginitis, local therapy produces a more rapid effect. Over the course of several weeks, in the experience of most investigators, a thick, velvety mucosa is usually produced, with good cornification of the superficial epithelium.^{10,11,20} In specific instances, antibacterial agents combined with estrogen have also been used with success.^{6,9} Falk and Hassid,¹² prior to vaginal plastic procedures, treat all patients of peri-menopausal age with estrogen cream applied vaginally, in an effort to render the the vaginal mucosa less friable at the time of operation. They recommend postoperative continuation of this form of therapy to assist in re-epithelization of the vagina.

In our group of study patients, the therapeutic effectiveness of intravaginal dienestrol, in both cream and suppository form, was highly satisfactory, as judged by clinical, colposcopic, vaginal (biopsy) and cytologic improvement. Cytohormonal indices reflect improvement as regards epithelial proliferation and maturation. It is possible, however, in view of the "falling below" seen at four weeks in those patients with a starting count value below 45 per cent, that a more successful cytologic response might have been elicited by extending the higher-frequency (nightly) dosage regimen, and perhaps also by preferential use of the suppository form, which seemed to confer some advantage.

Colposcopic examinations of the vulva, vagina and cervix during and after the treatment, as well as vaginal punch biopsies from the mid-posterior vaginal wall, proved to be useful aids in the diagnosis and treatment of atrophic vaginitis. Although estrogen administration in the menopause has proponents as well as opponents¹³, the experience of this study gives further support to the validity of the basic concept that treatment of

atrophic vaginitis with the topical medications employed can be effective, simple, and devoid of systemic problems.

Summary

The intravaginal application of dienestrol (cream and suppositories) in 48 cases of atrophic vaginitis was found to be an effective and acceptable method of treatment; the quantity of hormone required by local application is relatively small and therapeutic effect can be obtained rapidly and without the induction of systemic symptoms.

Acknowledgment

DV (dienestrol) Suppositories and DV (dienestrol) Cream were made available for clinical investigation by the producer of these medications, The National Drug Company, Division of Richardson-Merrell Inc., Philadelphia, Pennsylvania. Trademark: DV □

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Preoperative Radiation

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Pittsburgh

In recent years, there has been an effort in the treatment of head and neck cancer, to improve the results obtained by either surgery or irradiation alone. The reason for this is that excisional surgery in the head and neck has technically reached a high degree and an improvement in the cure rates obtained by this method are not likely.

The same is true of the techniques of supra-voltage irradiation. The effort is now being made, therefore, to combine the two modalities in the hope that the cure rate will be affected favorably. Obviously, the effects of the two modalities are not additive, but it is hoped that some statistically significant improvement can be realized.

Before we continue, I would like to make a point which I believe is axiomatic—and that is that irradiation therapy is no less radical than surgery. To combine the two methods indiscriminately, is no more justified than to do a supra-radical operative procedure when a much less radical operation would be adequate. In other words, a person would not be justified in doing a total laryngectomy in a patient whose outcome would be just as good with a partial laryngectomy.

Similarly, to pre-radiate a lesion which would have a favorable result with surgery alone, is no more justified than the preceding illustration.

Let's examine the modality of preoperative irradiation. If there is any benefit to radio-surgery, this should be examined in the light of the cold facts. Emotionalism, hunches and fads should be discarded.

Let us review the reasons for irradiation and surgical failures. When we examine the causes for surgical failure, we see that these are due to local factors and systemic

factors which are uncontrolled in the attempt to eradicate the cancer.

When analyzing systemic factors, we must consider the biologic nature of the malignancy itself. There are certain malignancies which have a propensity for vascular invasions early in their course. These tumors, obviously, are not going to be controlled by any modality available at the present time.

Another factor is the invasiveness of the tumor itself. Abnormal cell motility is oftentimes inherent in the tumor type itself. This oftentimes is spoken of as biologic determinism. In most epidermoid carcinomas of the head and neck, this is an acquired trait. In other words—the smaller tumors are usually younger and behave less malignantly with less of a propensity for metastasis. Whereas, the larger tumor, usually connotes a much older tumor with a higher degree of

malignancy. So, the size of the tumor is a factor.

The mode of dissemination of cancer to lymph nodes has been a question of much debate. (1) Whether there is a steady stream of cells in the afferent lymphatics, or whether embolization is the mechanism being debated, the present thinking is that metastasis represents embolization. (2) After a node is saturated, it may metastasize or embolize to another node, or to collateral nodes, using alternate lymphatics. This phenomenon is known as skip metastasize. The phenomenon of retrograde metastasis is well known. Direct metastasis through lymphatics, by-passing all the nodes and going to the thoracic duct and thereby into the blood stream is well established, as has been direct communications between lymphatics and venules directly into the blood stream. Therefore, it is no longer tenable to assume that lymph-borne metastases have only one destination—that is lymph node. They have access to the systemic circulation. It has been demonstrated that there are tumor cells in the circulation of all Grade III and Grade IV tumors. The prognostic significance has not been clarified.

The final factor in understanding metastasis, is the question of lodgment and growth. Most tumor cells in the blood stream die an intravascular death. The fate of the malignant cell in the blood stream depends on the stage or the grade of the tumor cell itself and on host factors. Several host factors and liver disease or trauma are important factors as to whether cells develop into metastatic foci. The fact that these tumor cells may lie in limbo and remain dormant for short or long periods of time until they are activated by some unknown factor



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(such as a liver disease) has been demonstrated in animals.

Local factors which cause failures surgically, are several as we can see here. The lack of knowledge of the extent of the disease preoperatively, may fool you and cause you to poorly plan an operative procedure. The impossibility sometimes of removing the whole of the disease by a surgical procedure in the head and neck, is the fact that certain vital structures and functional components may behave as a major deterrent, such as the base of the skull, carotid artery, etc. Oftentimes, seeding and spillage may occur leaving viable tumor cells within the wound.

So, we can see local factors involve incomplete removal of tumor, either due to the size of the tumor, location of the tumor, making surgical resection not possible. These are technical considerations. Another factor, of course, is seeding which is sometimes technical consideration also.

Therefore, we see that the pattern of tumor behavior and systemic spread are determined by anatomic factors, as well as intrinsic factors in the cell and in the host tissues. It is obvious at the present time, we do not have enough knowledge to favorably or unfavorably affect metastasis, and therefore, the rationale for preoperative irradiation must be looked for in improving factors which may favorably control the disease locally.

Now, I would like to examine the rationale for preoperative irradiation. I think as stated before, when the prevailing treatment has a high incidence of cure, additional treatment with possible slight improvement of cure rate is not justified if the complications are multiplied by combined treatment. Similarly, when the disease is already disseminated, there is no point in using the two modalities jointly.

The effects of irradiation are both on the host and on the tumor cell. Host effects are as follows: (1) fibrous encapsulation with the blockage of vessels and lymphatics occurs. (2) tumor cells are less likely to implant in an irradiated fibrous avascular area.

Cell effects: (1) The ionizing effect on the cell destroys the tumor cell. This effect is not demonstrable immediately by histologic examination. Histologic change is not necessary for benefit to occur. It is the biologic future of the cell that is important as far as what happens

to any spilled cells or any inadequately removed cells which may remain. The effect on the cell itself is maximum with a high oxygen tension and for this reason preoperative radiation is favored over postoperative radiation. (2) The number of viable cells that may be left in the wound are decreased. This is a factor of numbers now and we do not know how many viable cells are necessary for a recurrent tumor.

So, we see that the aim of the preoperative radiation, therefore, is to destroy viable cells within the lymphatics, reduce the number of viable cells at the periphery of the tumor and decrease the number of viable cells in the mass itself, with the result that the local recurrence of tumor due to spillage is decreased. The number of tumor cells introduced in the blood stream is decreased due to manipulation during surgery. The number of cells in the periphery of a tumor would be reduced and make unresectable tumors resectable, theoretically requiring smaller resection; thereby improving cosmetic and functional results.

Now, given the rationale for and the objectives of preoperative irradiation, the next important question which arises is the dosage, the time the dosage is given in, and the interval between the irradiation and the surgery. Should the dose be 2,000 r in one week and two weeks; 4,000 r in three weeks, four weeks, six weeks, or 6,000 r in six weeks? And, should the surgery be done at what interval following each radiated dosage? We actually lack knowledge regarding dosage in a specific time interval. We also lack knowledge as to what is the optimum surgical time after irradiation. We do know that a long delay has certain benefits in that it allows a regression of tumor, and also, allows sometimes evidence of systemic metastasis to occur, therefore avoiding possible radical surgery. But, does a long delay also allow the tumor cells to get over their dormancy within a tumor and pick up steam again?

One fact we do know is that a tumorcidal dose of 6,000 and a long waiting period of six weeks or more, causes complications which are unacceptable as a rule. Therefore, less than a tumorcidal dose must be given and a waiting period less than six weeks must be utilized.

In the light of the above information, let us see what characteristics and findings of a tumor are necessary to be

favorably affected by preoperative irradiation.

1. Large T3 and T4 lesions, I irradiate because of the above fact that large tumors are older tumors and have a higher degree of malignancy, and are more difficult to eradicate technically, and you are more likely to have some spillage.

2. Anatomically located lesions which are impossible to obtain adequate resection.

3. Biologically aggressive anaplastic tumors, in which the factor of biologic determinism plays a great factor, and finally,

4. The size and number of nodes in the neck. We do know that the cure rates are directly related to this factor. We have established the fact that nodes in the neck already means that there are tumor cells within the blood stream.

When you examine these factors, you will see that the cases that adapt themselves for preoperative radiation are exactly those cases for which you would normally give postoperative radiation. The determining factor here is the ineffectiveness of postoperative radiation due to decreased oxygen tensions within an operative field.

The choice of preoperative irradiation should be made on the following factors and not *carte blanche*. There are tumor factors which include the size of the lesion, site of lesions, histologic differentiation and the size and number of the nodes. There are patient factors to be considered too, i.e. salvageable life expectancy if cured; the cure rates and the knowledge and skill of the surgeon and radiotherapist.

In summary then, in epidermoid carcinoma of the head and neck, the decision regarding the administration of preoperative radiation should represent a balanced judgment. This is based on evaluation of the cause of failure and the objectives of preoperative irradiation. This implies a high degree of knowledge regarding the clinical behavior of tumors and a knowledge of the cure rates of tumors in regard to their size, site, metastasis, etc., an intimate familiarity with the anatomy and lymphatic drainage in the head and neck. This then, must be modified by the patient factors in question, and then further modified by the skills of the specific surgeon and radiotherapist. □



Management Of Malignant Melanoma



IN A LABORATORY, tissue samples are being processed for study.

While most skin cancers are preventable, early diagnosable and highly curable, the malignant melanoma remains an enigma. Its behavior is erratic and unpredictable; the outcome often fatal. Twenty years ago the five year survival rate was about 15 per cent. Today it is about 50 per cent an improvement but still bad.

Part of the explanation for such poor results is the intrinsic aggressiveness of the melanoma which spreads by local, lymphatic and hematogenous pathways. The benign appearance of some of the early lesions may delay the diagnosis. Any skin lesion that is black or blue-black and slightly elevated from the skin should be suspected. Definitive diagnosis is made only by biopsy. As in other types of cancer, the biopsy may be negative when clinically the lesion is very suspicious. Under such circumstances most surgeons withhold major definitive procedures, especially if disfiguring or disabling.

If the biopsy is positive, surgery is the procedure of choice. In early lesions or those with local spread only, a wide, deep excision with removal of regional nodes is done. If the tumor can drain to more than one set of regional nodes, observation of the nodes is usually elected rather than prophylactic excision. It is not possible to determine by palpation or gross visual examination whether the regional lymph nodes are involved and it is common experience to find, in nodes that are clinically negative, that the melanoma cells are already present.

Once the tumor has gone beyond the regional nodes, or hematogenous spread has occurred, the situation is usually beyond control. With rare exceptions, irradiation and chemotherapy so far, are ineffective.

There is no area in the field of oncology where a high index of suspicion, prompt biopsy diagnosis and adequate treatment mean so much to the patient's future.



Sudden Cardiac Death

Irving Imber, M.D., questions William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, Unionville, Pennsylvania.

What is the leading cardiovascular cause of sudden death?

Coronary atherosclerosis is the most common background, occurring in over 75 per cent of instances.

What, then, are the specific mechanisms causing sudden death in patients with this background?

Acute coronary occlusion may occur, followed quickly by cardiac rupture and hemopericardium. Another finding is cardiac arrest (or ventricular asystole). The background here is usually acute myocardial anoxia. Other causative mechanisms include vagal reflex action, deep anesthesia and direct or surgical manipulation of the heart or great vessels. In some instances, sudden hemorrhage in the brain and massive pulmonary embolism have been found. The latter may also occur in association with an acute myocardial infarction. If the autopsy fails to reveal the cause of sudden death, the presence of ventricular fibrillation should be suspected, particularly if coronary atherosclerosis can be demonstrated.

What other diseases of the cardiovascular system are commonly associated with sudden death?

Rheumatic aortic insufficiency may lead to sudden or unexpected death. However, a syphilitic lesion of this type is usually more common than a rheumatic one, probably as the result of fibrosis of the coronary vessels at their sites of origin. In syphilis, sudden death may also occur following the rupture of an aortic aneurysm.

Is sudden death apt to occur in patients known to have a single valvular lesion?

Yes. Aortic stenosis is perhaps the most common single valvular lesion associated with sudden death. However, evidence of other cardiac disease should always be sought, particularly when involvement of the coronary vessels is suspected at any age.

Does sudden cardiac death occur in younger age groups?

In children, congenital anomalies of the coronary vessels may be the background. I have seen one instance of sudden death in a high school girl of fifteen. In this patient, severe, sudden exertion may have been the precipitating factor. Sudden death can also occur in idiopathic cardiac hypertrophy, subaortic stenosis or Ebstein's disease. In congenital heart disease, cerebral complications, vascular thrombosis or bacterial endocarditis may result in sudden death.

Are there other factors to consider in assessing sudden death in the presence of cardiovascular disease?

Yes. Aspiration of body cavities may be a rare causative factor. So may rupture of a cerebral aneurysm, a dissecting aneurysm of the aorta or acute gastro-intestinal bleeding in middle age or beyond. Quite often even a thorough post mortem examination of the patient will fail to reveal the exact cause.

Can sudden cardiac arrest be prevented?

Often this is possible. At operation, for example, much will depend on the anesthetist and surgeon. In this respect, adequate oxygen concentration in the anesthetic mixture is essential, together

with prompt replacement of blood loss and a minimum amount of manipulation and distortion of the heart and great vessels. Recently, cardiac care units and their around-the-clock operation in most hospitals have allowed us to pin-point a dangerous cardiac arrhythmia in its incipency and institute prompt treatment.

Should further research be carried out to enable us to differentiate those patients presenting a risk of sudden death?

I believe so. Portable care units have been proposed to furnish more prompt treatment in emergencies. To meet this need, the type of emergency should be recognized as soon as possible and treatment should be carried out according to a previously worked out plan. These units should be available in all densely populated urban areas. Finally, I believe that the value of drugs in the prevention of sudden death is open to question.

Are there any instances of sudden death in patients with apparently normal hearts?

There have been recent reports of glue sniffing, particularly among teenagers, followed by sudden death brought about by a severe cardiac arrhythmia. The toxic elements involved here are usually volatile hydrocarbons. In this category we can also include the teen-age habit of inhaling from plastic bags previously sprayed from aerosol cans of hair sprays, cleaning fluid, etc. In many instances, it has been shown that if severe exertion should follow the sniffing, sudden cardiac death may occur.

William G. Leaman, Jr., M.D., has prepared this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help—for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

THE STOPPER



LOMOTIL[®]

tablets/liquid

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

first aid in diarrhea of acute gastroenteritis

PROMPT ANTIDIARRHEAL ACTION

Roentgenographic studies demonstrate that the motility-lowering activity of Lomotil is concentrated in the first three hours and continues for at least six hours.

Clinical investigators have found ample confirmation of these determinations. Lomotil has reduced diarrheal urgency in many patients within one hour.

OPTIMAL ANTIDIARRHEAL CONTROL

Numerous investigators have remarked on the high degree of effec-

tiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

UNSURPASSED ANTIDIARRHEAL ACCEPTANCE

Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdose may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pin-

point pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age. Maintenance dosage may be as low as one-fourth the initial daily dosage.

in cardiac edema

Dyazide[®] Trademark

Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triam-

terene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

**SK
&F**

Smith Kline & French Laboratories

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PROCEEDINGS OF THE HOUSE OF DELEGATES

One Hundred and Twenty-First Annual Session
Lancaster, Pennsylvania—October 5-7, 1970

The House of Delegates of the Pennsylvania Medical Society convened its 121st Annual Session at 7:52 p.m., October 5, 1970 in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster, with William Y. Rial, M.D., Speaker of the House, presiding. John H. Hobart, M.D., Chairman of the Committee on Credentials, reported that a quorum was present. Robert S. Sanford, M.D., Trustee and Councilor from the Seventh District, gave the invocation.

The first meeting, which continued until 10:15 p.m., included the addresses of President William A. Barrett, M.D. and President-Elect, William A. Limberger, M.D.

The second meeting was convened at 9:10 a.m., October 7, 1970 at which time the report of the Reference Com-

mittee on Constitution and Bylaws was adopted. Following elections, the reference committee reports on Reports of Standing and Special Committees, Reports of Officers, Public Service and Miscellaneous Business were acted upon. The House recessed at 12:00 noon for lunch and balloting, reconvening at 1:40 p.m. at which time it acted on the reference committee reports of Education and Science, Medical Service and Governmental Relations.

The House of Delegates approved the recommendation of the Board of Trustees and Councilors that the 1971 annual assessment remain at \$75 for each full dues-paying active member.

The 121st Session of the House of Delegates adjourned sine die at 4:10 p.m. Wednesday, October 7, 1970.

Editor's Note: In those cases where the House of Delegates voted against the recommendation of the Reference Committee report, that action is specifically stated. Support by the House of Delegates for the recommendations of the reference committee may be assumed unless opposition is specifically stated.

The Opening Session of the House, October 5, 1970

The Speaker called the opening session of the 1970 House to order at 7:52 p.m., Monday evening, October 5, 1970 in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster. After hearing a report from John H. Hobart, M.D., Chairman of the Credentials Committee, that a quorum was present, Dr. Rial called upon Dr. Sanford to deliver the invocation.

Committee on Rules

William R. A. Boben, M.D., Chairman, presented the following report of the Committee on Rules, which was adopted by the House:

1. Standing Rules of the House of Delegates (Page 4 of the Official Reports Booklet)

The Standing Rules being submitted to the House on page four of the Official Reports Booklet are the same as those adopted last year. In recommending that they be

approved again, we wish to remind you that several procedural items will be considered this year.

Roman numeral III of the Official Call, page 6 of the Official Reports Booklet, is an amendment to the Bylaws which would substitute Sturgis Standard Code of Parliamentary Procedure for Robert's Rules of Order, Revised. This will impact on Standing Rule No. 2.

Resolution 70-6: Change in Voting Procedure in the House of Delegates, page 148, impacts on Standing Rule No. 1.

Mindful of the changes which may occur Wednesday morning, we recommend that the four standing rules printed in the Official Reports Booklet be adopted.

2. Proposed Standing Rule No. 5.

If Resolution 70-6, "Change in Voting Procedure in the House of Delegates" is adopted Wednesday morning, a new standing rule will be necessary. In anticipation we have drafted Standing Rule No. 5 which we present now for your information: Proposed Standing Rule No. 5 reads:

"To expedite the work of the House, balloting will be held during the noon recess of the second session of the House. Each delegate seated, as of and including the second session of the House, will during the noon recess, identify himself to a member of the Credentials Committee at a location which will be announced by the Speaker. At that time he will receive his ballot. After marking his ballot he will deposit it in the ballot box manned by the tellers. The opening and closing times of the polls will be announced by the Speaker."

Mr. Speaker we recommend that proposed Standing Rule No. 5 be introduced as part of the official business of the House so that it may be voted upon Wednesday morning if necessary.

Let me add, parenthetically, that should Standing Rule No. 5 be adopted, it will not be necessary for members to write down the names of nominees as in previous years. The ballot you would pick up at noon would have on it the names of all candidates.

3. Four recommendations on improved procedures regarding the report of the Committee to Nominate Delegates and Alternates to the AMA as proposed by George A. Rowland, M.D., Trustee and Councilor from the Fourth District and approved by the Board of Trustees. (Official Reports Booklet, Appendix A, page 119)

"I. My first recommendation is that the ballots for delegates and alternates be made up in advance with printed names of the committee nominees alone. The remainder of the ballot would have blank spaces for writing in nominees from the floor. Also, at the recent convention, the delegates who cast ballots heard, on the day of election, speeches for only two candidates with no rebuttal despite the fact that one of these was highly emotional and by inference critical of the committee's actions. Many of the voters may not even have been present for the report of the committee on Thursday night. At any rate it was two days before. Nothing but a flat statement of approval was given the individuals nominated by the committee.

II. I recommend secondly that the report of the committee give a summary of activities of each member of the delegation whose term has expired. This would include his age, length of service on the delegation, and his activities on the delegation in the past year. A similar report should be made of the alternates. There should be a summary of activities of new nominees also, including age.

III. Thirdly, I suggest that the report of the committee be presented at the time of the election to have full impact. If there is objection to this, it might still be permissible to supply the list of nominees in the delegates' packet at the opening session.

IV. Fourth, I suggest that if the election is contested, that any or all of the nominees of the committee will have the right to seconding speeches. The number and duration of these will be decided by the Speaker."

Mr. Speaker, the Committee on Rules considered each of these suggestions from Dr. Rowland, and has no objection to them. We recommend that they be adopted in principle with the understanding that they become effective January 1, 1971. If the House accepts our recommendation Dr.

Rowland's suggestions will be rewritten as standing rules and appear in the Official Reports Booklet next year.

Necrology Report

The House stood in tribute to receive the following necrology report presented by Park M. Horton, M.D., chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

From September 1, 1969 to August 31, 1970, we have lost by death 285 members; 31 not over 50 years of age; 110 between 51 and 70; and 144 in the group aged 71 to over 90. Of these 285 members, 106 were associates, most of whom were 65 years of age or over. The necrology report at the last Annual Session reported the loss of 274 members. May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

Report of the Standing Committee on Constitution and Bylaws

R. Robert Tyson, M.D., Chairman, referred to the report of the Standing Committee on Constitution and Bylaws as published on page 69 of the Official Reports Booklet, and to the proposed amendments to the Constitution and Bylaws contained in the Official Call on pages 5-7 of the Official Reports Booklet. These materials were received as official business by the House of Delegates.

Committees of the 1970 House of Delegates

The speaker announced that the following appointments had been made to committees of the House:

Committee on Credentials

John H. Hobart, M.D., Northampton County, Chairman
Robert J. Carroll, M.D., Allegheny County
George A. Hahn, M.D., Philadelphia County
Earle L. Keeter, M.D., Schuylkill County
John F. Kennard, M.D., Clearfield County

Committee on Rules

William R.A. Boben, M.D., Luzerne County, Chairman
George Berg, M.D., Allegheny County
Ralph R. Brown, M.D., Indiana County
David S. Cristol, M.D., Philadelphia County
Donald W. Gressly, M.D., Beaver County

Tellers

John P. Manges, M.D., Franklin County, Chairman
Samuel D. Kron, M.D., Philadelphia County
Edgar H. Lutz, M.D., Susquehanna County
Kenneth F. Miller, M.D., Allegheny County
Thomas E. Patrick, M.D., Columbia County
William C. Ryan, M.D., Somerset County
Dennis A. Sharkey, Jr., M.D., Elk-Cameron County

Committee on Constitution and Bylaws

R. Robert Tyson, M.D., Philadelphia County, Chairman

William F. Donaldson, Jr., M.D., Allegheny County
Charles P. Hammond, M.D., Lancaster County
Vorrle B. Macom, M.D., Carbon County
H. William Stewart, M.D., Huntingdon County

Committee on Education and Science

James B. Donaldson, M.D., Philadelphia County,
Chairman

Frank J. DiLeo, M.D., Lehigh County
Fred C. Brady, M.D., Allegheny County
Charles R. Sloan, M.D., Fayette County
Ernest C. Wynne, III, Jefferson Medical College

Committee on Governmental Relations

Ralph C. Wilde, M.D., Allegheny County, Chairman
John D. Alexander, Jr., M.D., Philadelphia County
William H. Frank, M.D., Cambria County
J. Preston Hoyle, M.D., Union County
William Lamberton, M.D., Erie County

Committee on Medical Service

John L. Steigerwalt, M.D., Montgomery County,
Chairman

Jack C. W. Brooks, M.D., Lawrence County
Lester A. Dunmire, M.D., Allegheny County
Robert P. Dutlinger, M.D., Dauphin County
Brooke Roberts, M.D., Philadelphia County

Committee on Miscellaneous Business

Richard I. Darnell, M.D., Bucks County, Chairman
Anthony J. Cummings, M.D., Lackawanna County
Robert Byers, M.D., Erie County
John Helwig, Jr., M.D., Philadelphia County
Robert M. Moyers, M.D., Crawford County

Committee on Public Service

Hunter S. Neal, M.D., Delaware County, Chairman
William B. Birch, M.D., Greene County
Paul S. Friedman, M.D., Philadelphia County
S. Victor King, M.D., Blair County
Ross E. Williams, University of Pittsburgh
School of Medicine

Committee on Reports of Officers

Milton M. Perloff, M.D., Philadelphia County,
Chairman
Ernest L. Abernathy, M.D., Washington County
Frederick C. Duffy, M.D., Allegheny County
John H. Harris, Jr., M.D., Cumberland County
Arlington A. Nagle, M.D., Berks County

Committee on Reports of Standing and Special Committees

Idilio J. Saldana, M.D., Jefferson County, Chairman
Howard W. Baker, M.D., Philadelphia County
Willard W. Christman, M.D., Northumberland County
Hollis K. Russell, M.D., Wyoming County
Whittier C. Atkinson, M.D., Chester County

Announcements by the Speaker

After introducing the members of the Board, Dr. Rial

called upon David S. Masland, M.D., for a special announcement concerning D. George Bloom, M.D., Trustee and Councilor from the Eleventh District.

"As many of you know, George Bloom has suffered another stroke and at this moment is in Conemaugh Valley Hospital, Johnstown. You also know that it was Dr. Bloom's plan to resign as trustee and councilor of the 11th councilor district because of poor health. Dr. Bloom's term will expire in 1971.

"It was a tremendous disappointment to the Board of Trustees to learn that George did not plan to continue to the end of his term. But we readily understood the reason why. During his years on the board, despite the sometimes unstable state of his health, George has been faithful in his attendance. His voice was impaired by his illness, but the integrity and honesty with which he spoke rang loudly in our ears. He was an example for all of us and we were extremely proud to have him as a member of the board. He was, in many ways, our plain-spoken, hard-bitten, irascible Socrates. Frequently he would sting us into a reconsideration of a program or an idea and make us reexamine the logic of our convictions. He wanted to make sure that what we did made sense and that we could reconcile it with our sense of integrity. He came to meetings that many men, feeling as he did, would simply not attempt to attend. He came on crutches, and when the cane or crutches were not ample support to get him there, He came with a nurse in attendance--- But he always came and he always did his duty. His sense of responsibility and his concern and love for his profession are evident in everything he does and says. We developed great affection and admiration for him. He will be sorely missed by all of us on the Board of Trustees.

"Because of his outstanding contribution in the service of his profession, because he is such a cardinal example of what it means to be committed to an ideal, I hope that this house of delegates will take formal recognition of his outstanding contributions to the Pennsylvania Medical Society and to his profession as a whole. His example has made us all better men."

At the conclusion of the statement, the House stood in tribute to Dr. Bloom.

Dr. Rial announced the following changes in membership of Reference Committees:

Education and Science

Delete Jack D. Myers, M.D., Allegheny
Add Fred C. Brady, M.D. Allegheny

Governmental Relations

Delete Harold J. Reinhard, M.D., Warren
Add William Lamberton, M.D., Erie

Standing and Special Committees

Delete James C. Gehris, M.D., Northumberland
Delete George W. Shaffer, M.D., Bucks
Add Whittier C. Atkinson, M.D., Chester
Add Willard W. Christman, M.D., Northumberland

Miscellaneous Business

Delete Francis W. Feightner, M.D., Westmoreland
Add Robert Byers, M.D., Erie

Credentials

Delete Joseph V. Caliguiri, M.D. Allegheny
Add Robert J. Carroll, M.D., Allegheny

Approval of Proceedings

The proceedings of the 120th Annual Session held in

Philadelphia, October 9-11, 1969, were approved as published in the December, 1969 issue of PENNSYLVANIA MEDICINE.

Remarks of President of Woman's Auxiliary

Mrs. John A. Schneider, President, Woman's Auxiliary to the Pennsylvania Medical Society, addressed the House, and her remarks (Appendix A) were referred to the Reference Committee on Standing and Special Committees.

Address of the President

William A. Barrett, M.D., President, presented a report on his year as president (published November, 1970, PENNSYLVANIA MEDICINE). Dr. Barrett's address, except for the portions listed below, was referred to the Reference Committee on Reports of Officers.

- (A) Health Care Manpower, Medical Education and Medical School Expansion: Reference Committee on Education and Science
- (B) Allied Health Care Personnel: Reference Committee on Education and Science
- (C) Medical Practice Act: Reference Committee on Governmental Relations
- (D) Continuing Medical Education and related Appendix A: Reference Committee on Education and Science
- (E) Legislation and PaMPAC:
 - (1) Portion dealing with PaMPAC: Reference Committee on Reports of Officers
 - (2) Portion dealing with legislative committees: Reference Committee on Governmental Relations
- (F) Medical Service: Reference Committee on Medical Service
- (G) Prepaid Insurance Programs: Reference Committee on Medical Service
- (H) Social Security Administration: Reference Committee on Medical Service
- (I) Peer Review: Reference Committee on Governmental Relations
- (J) Foundation for Medical Care: Reference Committee on Medical Service
- (K) Public Service: Reference Committee on Public Service

Recommendations from Dr. Barrett's address appear as Appendix C.

Address of the President-Elect

The remarks (published November, 1970 PENNSYLVANIA MEDICINE) of President-Elect William A. Limberger, M.D., were referred as indicated below:

- (A) Introduction: Reference Committee on Reports of Officers
- (B) Manpower: Medical and Allied Health Personnel
 - (1) Portion dealing with liberal arts colleges and community hospitals: Reference Committee on Education and Science
 - (2) Portion dealing with increased financial support for medical students: Reference Committee on Governmental Relations
 - (3) Portion dealing with a bond issue for new medical schools: Reference Committee on Governmental Relations
- (C) Medical Education: Reference Committee on Education and Science
- (D) Continuing Education: Reference Committee on Edu-

cation and Science

- (E) Allied Health Personnel: Reference Committee on Education and Science
- (F) Delivery of Health Care:
 - (1) Portion dealing with neighborhood health centers: Reference Committee on Medical Service
 - (2) Portion dealing with the West Perry Clinic: Reference Committee on Public Service
- (G) Peer Review: Reference Committee on Medical Service
- (H) Communications: Reference Committee on Public Service
 - (1) Litigation and Insurance for Medical Liability: Reference Committee on Medical Service
- (J) PaMPAC and Conclusion: Reference Committee on Reports of Officers

Recommendations from Dr. Limberger's address appear as Appendix D.

Distinguished Guests

The following distinguished guests were presented to the House:

Henry H. Stroud, M.D., President, Medical Society of Delaware; Emanuel M. Satulsky, M.D., President, Medical Society of New Jersey; P. John Robeck, M.D., President-Elect, Ohio State Medical Association; George R. Callender, Jr., M.D., President, West Virginia Medical Association; Mrs. R.C.L. Robertson, Houston, Texas, President, Woman's Auxiliary to the AMA; Bernard Shair, D.D.S., President, Pennsylvania Dental Association; James B. Leedy, President, Pennsylvania Pharmaceutical Association; Marvin Comisky, Esq., President, Pennsylvania Bar Association; Joseph W. Stella, D.O., President-Elect, Pennsylvania Osteopathic Association; Edward H. Hale, M.D., President, Keystone Medical Society; Jean M. Reidnour, R.N., President, Pennsylvania Nurses Association; Jane M. McNulty, President, Pennsylvania Association of Medical Assistants; Mrs. Agnes Smith, R.N., President-Elect, Pennsylvania Association of Medical Assistants; Theodore C. Bedwell, Jr., M.D., Chief Medical Officer, Social Security Administration.

The remarks of Dr. Stella appear as Appendix I.

SAMA Delegates

The following SAMA delegates also were introduced:

Ross E. Williams, University of Pittsburgh School of Medicine; Burke Cunha, Penn State University College of Medicine; Charles W. Everhart, Jr., Hahnemann Medical College and Hospital; Ernest C. Wynne, III, Jefferson Medical College; Miss Barbara E. Hancock, The Medical College of Pennsylvania; Richard Shames, University of Pennsylvania School of Medicine; David Galinsky, Temple University School of Medicine.

Acceptance of Reports and Resolutions

All material contained in the 1970 Official Reports Booklet, including Resolutions 70-1 through 70-14 and the following Supplemental Reports were accepted as the official business of the House:

- (1) Board of Trustees and Councilors, (A), (B), (C) and (D)
- (2) Pennsylvania Delegation to the AMA
- (3) Committee on Objectives
- (4) Council on Education and Science
- (5) Council on Medical Service (A) and (B)
- (6) Judicial Council

The following supplemental reports in the delegates' packets were received as official business of the House:

- (1) Reference Committee Survey polling delegates regarding their willingness to serve on a 1971 reference committee
- (2) Supplemental Report of the Council on Governmental Relations (Referred to the Reference Committee on Governmental Relations) Appendix G
- (3) Blue Shield Report (Referred to the Reference Committee on Medical Service) Available on Request
- (4) Annual Report of the Educational and Scientific Trust (Referred to the Reference Committee on Reports of Standing and Special Committees) Available on Request
- (5) Supplemental Report from the Trustee and Councilor for the Ninth District (Referred to Reference Committee on Reports of Officers) Appendix J
- (6) Supplemental Report (E) from the Board of Trustees and Councilors (Referrals indicated in report which is published as Appendix B)
- (7) Proposed budget for 1971—Available on Request

The following ten resolutions received after September 5, 1970, were accepted as business of the House of Delegates:

RESOLUTION NO. 70-15: Definitive Interpretation of "Sole Arbiter" Principle, introduced by Brooke Roberts, M.D., in behalf of the Philadelphia County Medical Society, referred to the Reference Committee on Reports of Officers

RESOLUTION NO. 70-16: Commitment Under the Mental Health/Mental Retardation Act 1966, introduced by Brooke Roberts, M.D. in behalf of the Philadelphia County Medical Society, referred to the Reference Committee on Education and Science

RESOLUTION NO. 70-17: Recognition of Physicians' Charitable Services, introduced by Edwin Price, M.D., in behalf of the Somerset County Medical Society, referred to the Reference Committee on Medical Service

RESOLUTION NO. 70-18: Improved Method of Payment to Physicians under the Commonwealth's Medical Assistance (Pennsycare) Program, introduced by Edwin Price, M.D., in behalf of the Somerset County Medical Society, referred to Reference Committee on Medical Service

RESOLUTION NO. 70-19: Termination of Chiropractic Licensing in Pennsylvania, introduced by Frank J. DiLeo, M.D., in behalf of the Lehigh County Medical Society, referred to the Reference Committee on Governmental Relations

RESOLUTION NO. 70-20: Medical Assistance Program, Commonwealth of Pennsylvania, introduced by Stephen J. Takach, M.D., in behalf of the Indiana County Medical Society, referred to the Reference Committee on Medical Service

RESOLUTION NO. 70-21: Medicare, Part C, introduced by John D. Alexander, Jr., M.D., Philadelphia, referred to Reference Committee on Medical Service

RESOLUTION NO. 70-22: Drug Abuse, introduced by

Joseph T. Ichter, M.D., in behalf of the Bucks County Medical Society; first Resolve is referred to the Reference Committee on Governmental Relations and the second Resolve is referred to the Reference Committee on Public Service, with the Whereas sections referred to both for their information

RESOLUTION NO. 70-23: Bicentennial of the Independence of the United States of America, introduced by S. X. Radbill, M.D., N. H. Moss, M.D., E. L. Housel, M.D., S. O. Krasnoff, M.D., and R. S. Pressman, M.D., Philadelphia, referred to Reference Committee on Public Service

AMENDED RESOLUTION NO. 70-10: Performance of Abortions in the State of Pennsylvania, introduced by Brooke Roberts, M.D., in behalf of the Philadelphia County Medical Society, referred to Reference Committee on Governmental Relations

RESOLUTION NO. 70-24: Meeting on the Clinical Aspects of Geriatric Medicine Prior to the White House Conference on this subject, introduced by the Board of Trustees and Councilors (Supplemental Report E), referred to Reference Committee on Education and Science

Finance Committee Report

David S. Masland, M.D., Chairman, presented the following report from the Finance Committee of the Board of Trustees and Councilors:

"A copy of the proposed budget for 1971 as approved by the Board of Trustees has been distributed for your information. In addition to the 1971 figures, it contains the comparative figures of the approved budget for 1970, as well as the actual expenditures incurred for the first six months of 1970.

"The 1971 budget is based on the current annual assessment of \$75 per full dues paying member. You will note that the budget anticipates a deficit of \$18,826. Were it not for the reimbursement that the Society receives for administrative services rendered to the Susquehanna Valley Regional Medical Program, which is estimated at \$111,202, the budget would show a deficit of \$127,000.

"The Society's income for 1971 will decline, according to the projections of the Finance Committee. The reason for this is that there has been a slight decline in income from membership dues in 1970 and we are basing our projection for 1971 on 1970 actual figures. It is also anticipated that income from PENNSYLVANIA MEDICINE will go down in 1971. However, our costs will not decline, nor will they remain the same. They will go up. For the past few years, the Society has been able to avoid the necessity of a dues increase by virtue of the prudent expenditure of funds by councils and committees, many of which registered surpluses at the year end, and by the fact that the Pennsylvania Medical Society has received substantial reimbursement for its services from the Department of Health, Education, and Welfare for its management of the Susquehanna Valley Regional Medical Program. Indeed, this has made it possible for the Society to register a substantial financial surplus when budget projections indicated that the surplus would be minimal or nonexistent. But this pleasant piece of history cannot repeat itself endlessly. The last dues increase for this Society went into effect in 1964. For six years, marked by some of the highest annual inflation rates in the history of this nation's economy, the Soci-

ety has been able to avoid an additional dues increase. During that time, the work of the Society has increased considerably and a new headquarters building was constructed without the need of a special building assessment. The mortgage on the property is minimal when the total value of the property, building and equipment is taken into consideration. I think it can be stated unequivocally that the membership received an excellent return on that last dues increase.

"But now the Society has turned the corner. The Finance Committee, the councils and the committees of the Society cannot indefinitely hold off the ravages of inflation, nor can we afford to curtail programs vital to the membership's interest and to the public good. I feel certain that when the Chairman of the Finance Committee presents his report to the 1972 House of Delegates, he will recommend an increase in dues. The handwriting is on the wall.

"I repeat my earlier statement that the budget before you is based on the current annual assessment. The Finance Committee is counting on the continued prudent expenditure of funds by the councils and committees and is hopeful that it can hold the line on the deficit at the current level by asking the various units of the Society to operate on an austerity basis in 1971. However, please bear in mind that every recommendation for a new or expanded project which you adopt during this meeting of the House of Delegates will cost money to implement. Increased expenses will result in a larger projected deficit for 1971.

"The Finance Committee plans to note and evaluate for budgetary purposes any new programs which you approve. Its recommendation for dues for 1971 will be presented at the final session of the House following the evaluation of the financial impact of your actions taken in connection with the various reference committee reports considered by the House in its various sessions. It is my hope that I will be able to bring to you a recommendation that the annual assessment for 1971 be the same as this year. That, however, is a matter which rests largely in your hands.

"If there are any questions concerning the budget or the financial condition of the Pennsylvania Medical Society, please attend the hearing of the Reference Committee on Reports of Officers. Members of the Finance Committee will be available to hear opinions and will attempt to answer any questions which arise. Thank you."

Committee to Nominate Delegates and Alternates to the American Medical Association

Edgar W. Meiser, M.D., Chairman, presented the following report of the committee:

The Committee to Nominate Delegates and Alternates to the American Medical Association has reviewed the activities of the Pennsylvania Delegation during the past year. In preparing this report to the 1970 House of Delegates, the Committee contacted Dr. Thomas W. McCreary, Sr., Chairman of the Delegation, requesting his opinion and evaluation of the current Delegation. In addition, the Committee scrutinized the ages and years of service of the delegates and alternates as well as the numerical and geographical balance of the Delegation.

It is the opinion of the Committee that the current delegates have served with enthusiasm and diligence at the AMA level and, therefore, we are taking this opportunity to nominate as delegates to the American Medical Association from Pennsylvania for two-year terms commencing January 1, 1971, the following member physicians to succeed themselves:

William A. Barrett, M.D., Allegheny County
Park M. Horton, M.D., Susquehanna County
Edmund L. Housel, M.D., Philadelphia County
William A. Limberger, M.D., Chester County
William Y. Rial, M.D., Delaware County
William B. West, M.D., Huntingdon County

The Committee noted that A. Reynolds Cranc, M.D., of Philadelphia, has served as an alternate delegate for ten years and indicated he did not necessarily want to stand for reelection.

Accordingly, the Committee nominates as alternate delegates to the AMA for two-year terms beginning January 1, 1971, the following member physicians:

R. William Alexander, M.D., Berks County
Jerome Chamovitz, M.D., Allegheny County
Leo C. Eddinger, M.D., Lehigh County
Raymond C. Grandon, M.D., Dauphin County
George A. Rowland, M.D., Columbia County
R. Robert Tyson, M.D., Philadelphia County

The Committee was informed that John F. Hartman, Jr., M.D., Erie County, has submitted his resignation as an alternate delegate. Dr. Hartman's term expires December 31, 1971, and the Committee nominates Robert F. Beckley, M.D., Clinton County, to fill the unexpired term.

Respectfully submitted,
Daniel H. Bee, M.D.
John B. Montgomery, M.D.
Edgar W. Meiser, M.D.,
Chairman

The opening session of the House adjourned at 10:15 p.m.

Second Session of the House, October 7, 1970

The second session of the House of Delegates was called to order in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster, Wednesday, October 7, 1970 at 9:10 a.m. The Credentials Committee reported that a quorum was present.

Memento to Carl B. Lechner, M.D.

The Speaker made the following announcement:

"Dr. David Keck, Trustee and Councilor from the Eighth Councilor District, has requested a special favor of the House with which your Speakers concur. He asks that we extend the best wishes of the House to Carl B. Lechner, M.D., Honorary Past President of the Society and Editor of PENNSYLVANIA MEDICINE, who is extremely ill and unable to be with us. We would like each member of the House to place his signature on a scroll which will be circulated to the House this morning and then sent to him after the close of this meeting."

Report of the Reference Committee on Constitution and Bylaws

R. Robert Tyson, M.D., chairman, presented the following report of the committee which was adopted by the House:

Note: Material which is underlined is being added. Material which is enclosed in [brackets] is being deleted.

1. Report of the Standing Committee on Constitution and Bylaws. (Pages 69-73 of the Official Reports Booklet)

We have reviewed the report of the Committee on Constitution and Bylaws and all of the items not referred to other reference committees are discussed below.

WE RECOMMEND the Report of the Committee on Constitution and Bylaws be filed for information.

2. Amendment to the Bylaws substituting Sturgis Standard Code of Parliamentary Procedure for Roberts Rules of Order (Page 6 of the Official Reports Booklet, and the Official Call, PENNSYLVANIA MEDICINE, July, 1970, pages 25 and 26)

"Sturgis Standard Code of Parliamentary Procedure" is the most recent accepted authority on this subject. The AMA has adopted this standard and has used it for their last two sessions. Our Speaker and Vice-Speaker believe this is a preferable standard.

Since no dissenting opinion was expressed in the reference committee hearing WE RECOMMEND a change in the Bylaws substituting "Sturgis Standard Code of Parliamentary Procedure" for "Roberts Rules of Order" as follows:

Bylaws, Chapter III, Section 6

"Rules of Order. [Robert's Rules of Order, Revised] Sturgis Standard Code of Parliamentary Procedure, Second Edition shall govern the proceedings of the House of Delegates unless otherwise provided in the Constitution or these Bylaws."

We note that the House of Delegates may determine the effective date of any amendment to the Bylaws.

WE RECOMMEND this change be effective immediately.

3. Resolution 70-6: Change in Voting Procedure in the House of Delegates. (Page 148 of the Official Reports Booklet)

The need and desire to streamline operating procedure in this House of Delegates stimulated the introduction of this resolution.

"RESOLVED, That Chapter IV, Section 2 of the Bylaws be amended to read as follows: 'The elections shall be conducted at a time and place determined by, and pursuant to rules promulgated by, the Committee on Rules and adopted by the House of Delegates by a majority vote'."

We heard only favorable comment about this resolution at the reference committee hearing. We believe this is a worthwhile amendment, that it will accomplish a saving of time and still permit sufficient control by the House to assure voting only by fully accredited members of the House of Delegates.

WE RECOMMEND the adoption of this amendment.

We note that the House of Delegates may determine the effective date of any amendment to the Bylaws.

WE RECOMMEND this change be effective immediately.

4. Amendments to the Constitution and Bylaws rescinding SAMA representation in the House. (Pages 6 and 7 of the Official Reports Booklet, and the Official Call, PENNSYLVANIA MEDICINE, July, 1970, pages 25 and 26.)

These amendments represent the unanimous opinion of the Beaver County Medical Society to the seating of the SAMA delegates as approved by this House last year. The reasons for this opposition are:

- (1) Belief that the rights and privileges of membership in this House should not be conferred on any non-paying member.
- (2) SAMA representatives are the equivalent of 700 dues paying members.
- (3) That this principle might be extended to Interns and Residents.

- (4) That no other professional organization or labor union has made similar changes.

Only the Beaver County group spoke in favor of these amendments opposing SAMA representation. Several other members spoke against these amendments opposing SAMA representation.

We believe these amendments should be defeated not only because this was the tenor of the reference committee hearing but because we believe SAMA representation will be an effective way to gain the opinions and participation of medical students which most of us desire. Although the effectiveness of seating SAMA representatives has not yet been demonstrated, we were pleased by the thoughtful comments and understanding expressed by those SAMA delegates at our reference committee hearing. Certainly the addition of seven delegates to this House will affect the outcome of the business of this House only to the degree that their opinions are valid. We believe this is a forward step of the Society and that we can provide leadership to those in other organizations which have not yet seen the merits of including student representation in their governing bodies.

WE RECOMMEND that these amendments be defeated.

5. Amendments to the Constitution and Bylaws to create a separate class of membership for Interns and Residents. (Page 5 of the Official Reports Booklet, and the Official Call, PENNSYLVANIA MEDICINE, July, 1970, page 25)

Currently Residents, with an unrestricted license to practice medicine in Pennsylvania, may achieve full membership in the Pennsylvania Medical Society upon the payment of 10 percent of the regular dues, provided a similar dues reduction is offered by the component county medical society. There is no provision for Intern membership. It has been the feeling of many members of this Society that we wish to encourage membership and activity by Interns as well as by Residents and Medical Students. The opinions expressed at the reference committee hearing were in favor of this principle and we concur. The only valid objection expressed was that these amendments would increase the delegate numbers in those counties already having large delegations. We believe that the positive advantages of having greater participation by Interns and Residents outweigh this disadvantage.

We have already agreed that participation without a vote has little attraction. The constitutional amendments as written, provide limitation of benefits and the waiving of all dues. The testimony at the reference committee hearing indicated that the payment of even partial dues may have a salutary effect on the active participation of an individual. We concur with this feeling but also believe that with the requirement of partial dues Interns and Residents should receive full benefits.

WE RECOMMEND adoption of amendments to the amendments that would impose on Interns and Residents a dues requirement that is 10 percent of the dues of the Pennsylvania Medical Society and which would provide full benefits. The amended amendments follow:

Amend Article IV of the Constitution, Section 5, Affiliate Member; Subsection (e)

"(e) physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, public health, or administrative medicine, [or hospital residency,] and..."

Insert a new Section 6 in front of the current Section 6, the new Section 6 to read as follows:

"Section 6, Intern and Resident Members—Intern

and Resident Members shall be persons serving an internship or a [hospital] residency in an accredited hospital in Pennsylvania.

[Neither Intern nor Resident Members shall be required to pay any annual assessment] Intern and Resident Members shall be required to pay 10 percent of the annual assessment."

[Section 6] amend to become Section 7

[Section 7] amend to become Section 8

[Section 8] amend to become Section 9

[Section 9] amend to become Section 10

Article XI — Funds

"Section 1, Annual Assessment—Money for the purposes of the Society shall be raised by annual assessment payable by each Active and each Senior Active member. The assessment for Active and Senior Active members shall be uniform except that the annual assessment for [those (a) serving hospital residencies or engaged in other forms of recognized full-time post-graduate training shall, during the period of such training, be 10 per cent of the regular annual assessment, provided the component society of which each is a member grants a corresponding reduction in its annual assessment (b)] (a) Interns or Residents during their period of training shall be 10 per cent of the regular annual assessment, provided the component society of which each is a member, grants a corresponding reduction in its annual assessment. (b) serving temporarily in the Armed Forces or other Government Service of the United States shall be excused for any assessment year in which the member enters service prior to March 1, is in service for the entire assessment year, or returns from service on or after March 1, and (c) prevented from the practice of medicine by reason of illness or disability shall be excused, provided the component society of which each is a member grants a corresponding exemption from its annual assessment. No annual assessment shall be payable by an Associate, Affiliate, [Intern or Resident] Special Student*, or Honorary Member..."

Bylaws Chapter 1 — Membership

Section 3.—Admission to Membership—(At the end thereof, add the following)

"Every member of a Component Society eligible to become an Intern or Resident Member of this Society shall become such upon receipt by the Executive Director of the certification required by Section 4 of Chapter XVI of these bylaws."

Section 4.—Limitations on Privileges of Membership.

"In addition to the limitations on the rights and privileges of membership contained in the Constitution of this Society and elsewhere in these Bylaws, neither Associate [nor], Affiliate, [Intern or Resident, or] nor Special Student* Members, unless expressly authorized in these Bylaws, shall be entitled to the benefits of any Medical Defense or other similar fund established by this Society, and Affiliate [Intern or Resident, or] and Special Student* Members shall not be entitled to the benefits of any Medical Benevolence or similar fund established by this Society."

Chapter XVI — Component Societies

Section 4.—Membership Records.—(At the end of

**The words "Special Student" are inserted to correct an oversight in 1969.*

the third sentence add)

.....Constitution [..], or (e) in the case of Intern or Resident Members, certifying that the member possesses the qualifications of such membership set forth in Section 6 of Article IV of the Constitution...."

6. Resolution 70-1: Expanded Membership of the Judicial Council. (Page 147 of the Official Reports Booklet)

WHEREAS, The ethical relationship between hospital boards and staffs is becoming increasingly complex and strained; and

WHEREAS, A recent ruling of our Judicial Council bordered on conflict with the tenets of the American Medical Association; and

WHEREAS, A portion of the Council members of our Judicial Council present at this hearing were paid by hospitals and therefore were employees of their hospitals. They therefore had a conflict of interest in making the decision rendered; therefore be it

RESOLVED, That the Bylaws of the Pennsylvania Medical Society be amended to expand the membership of the Judicial Council to nine members, at least six of whom shall be in the private practice of medicine and are not receiving any salary or remuneration of any sort from the hospital in which they serve.

This resolution recommended expansion of the Judicial Council to 9 members at least 6 of whom would be in the private practice of medicine. The testimony in the reference committee hearing, as well as the wording of this resolution conferred the impression that the reason for its introduction was for expedient purposes. The wording of the resolution is incorrect in that the Constitution of this society rather than the Bylaws must be amended.

In spite of the above observations, the reference committee testimony suggested we should seriously consider increasing the number of members on the Judicial Council for the following reasons:

- (1) It is quite possible, following the elimination of members from a hearing for many reasons including bias, three members would constitute a quorum. This means a decision can be made by two members. There is merit in the thought that a larger quorum might contribute more to a given decision.
- (2) The membership figure of five in the Judicial Council has not changed for many years while our membership has. Furthermore we are now entering into an era that will involve many social changes. The addition of members to the Judicial Council might very well contribute significantly to the proper adjudication of problems involving these social changes.

The proposed qualification that at least six members shall be in the private practice of medicine, will reduce significantly the already limited number of persons who are constitutionally qualified to be members of the Judicial Council and will in no way affect the opinions and bias of a member.

We believe the present qualifications for membership which restrict membership on the Judicial Council to those persons who have earned the respect of their peers and their understanding of the functions of the society by the importance of their position or term of service are still valid today.

WE RECOMMEND that Resolution 70-1 be amended so that the Standing Committee on Constitution and Bylaws is directed to further examine the advisability of increasing the number of members on the Judicial Council and to

report back to this House of Delegates at its next annual meeting with an appropriate recommendation.

The amended RESOLVED follows:

"RESOLVED, The Committee on Constitution and Bylaws be instructed to further investigate the advisability of increasing the number of members on the Judicial Council as well as changing the qualifications necessary for membership and that they bring to this House of Delegates at its next annual meeting an appropriate recommendation for the members of this House."

7. Amendment to the Bylaws permitting a chairman of a council or commission to be reappointed for three terms regardless of his tenure on the council or commission. (Page 6 of the Official Reports Booklet, and the Official Call, PENNSYLVANIA MEDICINE, July, 1970, page 25)

The testimony at the reference committee hearing indicated that this amendment was based on a lack of knowledge of the years of service of a member on a council or commission when considering the appointment of an experienced chairman. The Bylaws which restrict service to six years represent a worthy effort to provide for change on our very important councils and commissions. Although at close range many individuals may appear indispensable, this has not proven to be so in the past. Since there was little support for this proposal in the reference committee hearing we see no reason to change the Bylaws in this instance.

WE RECOMMEND the proposal be defeated.

8. Clarifying amendments to the Constitution concerning Honorary Members and Affiliates who are Missionaries. (Page 6 of the Official Reports Booklet, and the Official Call, PENNSYLVANIA MEDICINE, July, 1970 page 26)

Last year, when the definition of "physician" was revised in the Constitution, this definition was not carried through in those sections pertaining to physicians engaged in missionary or philanthropic labor nor was it changed in that section referring to Honorary Members.

WE RECOMMEND the adoption of the clarifying amendments to the Constitution as indicated in the Official Reports Booklet by the Standing Committee on Constitution and Bylaws.

9. Amendments to the Constitution and Bylaws giving voting rights to Associate Members. (Pages 5 and 6 of the Official Reports Booklet; and the Official Call, PENNSYLVANIA MEDICINE, July, 1970, page 26)

This recommendation stimulated considerable discussion in the reference committee hearing. The gist of this discussion was not in favor of the amendments.

- (1) The amendments violate the previously stated principle that individuals should pay at least a nominal fee so that active participation will be stimulated.
- (2) There are many physicians licensed to practice medicine in the state of Pennsylvania who are not members of this Society. They can be recruited to increase our membership.
- (3) The reason for this amendment was to meet a predicted immediate problem.

From a philosophical standpoint expediency is a poor reason to change a Constitution and Bylaws especially when other means can readily be found to meet the current problem.

- (4) There are ample means whereby the older physician may continue to be an active participant in this society by paying nominal dues.

WE RECOMMEND the defeat of these amendments.

Committee on Rules

William R.A. Boben, M.D., chairman, presented the following report to the House:

Standing Rule No. 5: Voting Procedure of the House

Inasmuch as the House of Delegates has just adopted Resolution No. 70-6, "Change in Voting Procedure in the House of Delegates," it is now appropriate for the delegates to consider Standing Rule No. 5:

"To expedite the work of the House, balloting will be held during the noon recess of the second session of the House. Each delegate seated, as of, and including the second session of the House, will during the noon recess, identify himself to a member of the Credentials Committee at a location which will be announced by the Speaker. At that time he will receive his ballot. After marking his ballot he will deposit it in the ballot box manned by the tellers. The opening and closing times of the polls will be announced by the Speaker."

Mr. Speaker, we recommend Standing Rule No. 5 be adopted and that it become effective immediately.

Elections

Elections were held Wednesday, October 7, 1970. The following officers were elected:

President-Elect: George P. Rosemond, M.D., Philadelphia County; First Vice-President: Charles K. Rose, Jr., M.D., Lehigh County; Second Vice-President: Orlo G. McCoy, M.D., Bradford County; Third Vice-President: Charles A. Bikle, M.D., Franklin County; Fourth Vice-President: Edward T. Lis, M.D., York County; Secretary: Raymond C. Grandon, M.D., Dauphin County; Speaker, House of Delegates: William Y. Rial, M.D., Delaware County; Vice-Speaker, House of Delegates: John B. Lovette, M.D., Cambria County; Trustee, Third District: Ralph K. Shields, M.D., Northampton County; Trustee, Ninth District: Cyrus B. Sleese, M.D., Armstrong County; Trustee, Eleventh District: William C. Ryan, M.D., Somerset County.

The following were elected as Delegates to the American Medical Association for a term of two years (from January 1, 1971 to December 31, 1972):

William A. Barrett, M.D., Allegheny County; Park M. Horton, M.D., Susquehanna County; Edmund L. Housel, M.D., Philadelphia County; William A. Limberger, M.D., Chester County; William Y. Rial, M.D., Delaware County; William B. West, M.D., Huntingdon County.

The following were elected as alternate delegates to the American Medical Association for a term of two years (From January 1, 1971 to December 31, 1972):

R. William Alexander, M.D., Berks County; Jerome Chamovitz, M.D., Allegheny County; Leo C. Eddinger, M.D., Lehigh County; Raymond C. Grandon, M.D., Dauphin County; George A. Rowland, M.D., Columbia County; R. Robert Tyson, M.D., Philadelphia County.

Robert F. Beckley, M.D., Clinton County was elected an alternate to fill the one year unexpired term of John F. Hartman, M.D. of Erie County who resigned.

Fred C. Brady, M.D., Allegheny County, was elected to a three year term on the Committee to Nominate Delegates and Alternates to the AMA.

M. Louise C. Gloeckner, M.D., Montgomery County, was elected to a five-year term on the Judicial Council.

The following District Censors were elected for a one year term:

Adams, James H. Allison; Allegheny, Robert A. Schein; Armstrong, Arthur R. Wilson; Beaver, Herman Bush; Bedford, James K. Gordon; Berks, Eugene Mendelsohn; Blair, John W. Hurst; Bradford, Willis W. Redding; Bucks, Stanley F. Peters; Butler, W.R. Fitzsimmons; Cambria, Warren F. White; Carbon, James M. Steele; Centre, H. Richard Ishler; Chester, Grant W. Bamberger; Clarion, Theodore R. Koenig; Clearfield, Fred Pease; Clinton, George J. Treires; Columbia, G.P. Moser; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Hamblen C. Eaton; Delaware, Edward G. Torrance; Elk-Cameron, James L. Hackett, Sr.; Erie, Robert L. Loeb; Fayette, Othello S. Kough; Franklin, Albert W. Freeman; Greene, W.W. Bartholomew; Huntingdon, Frederick H. Steele; Indiana, Samuel Cohen; Jefferson, Franklin S. Bizousky; Lackawanna, John C. Sanner; Lancaster, William A. Atlee; Lawrence, Gerald H. Weiner; Lebanon, C. Raymond Bell, Jr.; Lehigh, Frederick R. Bausch, Jr.; Luzerne, Donald F. Closterman; Lycoming, Wilfred W. Wilcox; McKean, Ralph Hockenberry; Mercer, Robert E. Sass; Mifflin-Juniata, John R. Hunter, Jr.; Monroe, Claus G. Jordon; Montgomery, Rudolph K. Glocker; Montour, Isaac L. Messmore; Northampton, Walter J. Filipek; Northumberland, J. Mostyn Davis, Jr.; Perry, Frank A. Belmont; Philadelphia, Charles M. Thompson; Potter, H.C. Mosch; Schuylkill, Joseph T. Marconis; Somerset, Alexander Solosko; Susquehanna, Raymond C. Davis; Tioga, James W. Montague; Union, John S. Purnell, Sr.; Venango, George S. Smith; Warren, Donald J. Furman; Washington, Herbert J. Levin; Wayne-Pike, Howard R. Patton; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, William C. Langston.

Report of the Reference Committee on Standing and Special Committees

Idilio J. Saldana, M.D., Chairman, presented the following report which was adopted as amended.
Committee on Aid to Education (Official Reports Booklet-page 66)

Mr. Speaker, we commend the work of the Committee which shows the continuing interest of the Society in providing financial aid to medical students. We note the decision of the Committee and the trustees of the Trust to suspend the scholarship program in favor of repayable loans and recommend that this policy be continued.

We recommend that the \$8.00 allotment per active dues member be continued for 1971.

Advisory Committee to the Woman's Auxiliary (Official Reports Booklet-page 69)

Speech of the President of the Woman's Auxiliary (Appendix A)

We commend the Auxiliary for its continuing work and recommend that the report and the address be filed for information.

Committee on Relationships with Allied Professions (Official Reports Booklet-page 73)

We commend the Committee for continuing the Physician/Nurse Seminars and we encourage more active physician participation. We also commend the Committee for its liaison with the various organizations listed in their report and urge them to enlarge upon it where advisable.

We recommend that this report be filed for information.
Committee on Medical Benevolence (Official Reports Booklet-page 74)

We commend the work of the Committee and we recommend the approval of its recommendation for the continua-

tion of the \$1.00 allotment per active dues member in 1971.
Committee on Objectives (Official Reports Booklet-page 75)

We recommend the approval of the Committee's recommendation that the Committee to Nominate Delegates and Alternates to the AMA be enlarged to include one representative from each councilor district and that the Committee be instructed to nominate more candidates than there are offices to be filled.

The above recommendation was adopted and referred to the Standing Committee on Constitution and Bylaws.

We recommend the approval of the Committee's recommendation that the direct election of Society officers by secret mail ballot not be adopted.

We recommend the approval of the Society objectives as written and as amended in the supplemental report of the Committee. We note that the Board of Trustees also recommended that these objectives be approved. We would encourage the Committee to pursue more concrete measures to achieve these objectives.

Board of Trustees Supplemental Report E (Appendix B)

We endorse the position of the Board of Trustees as contained in the Supplemental Report (recommendations concerning the composition of the Committee on Objectives). We recommend the Committee on Objectives be limited to seven members. In order to assist the President in implementing this action we recommend the following:

1. No new appointments should be made for the coming year (1970-71) since five of the members' terms expire.
2. In the succeeding year (1971-72), the terms of five additional members will expire and only two appointments should be made, bringing the membership to seven.
3. In the next year (1972-73), the terms of five additional members will expire. The President will then appoint five members, two of whom will serve a one year term. The remaining three appointees will serve for the full three year term. This will set a pattern so that in two years of each three year period, two members will be appointed and in the third year three members will be appointed.

The House referred the above recommendation regarding the size of the Committee on Objectives to the Standing Committee on Constitution and Bylaws.

Committee on Discipline (Official Reports Booklet-page 78)

We commend the work of the Committee and recommend that this report be filed for information.

Committee to Study Relations between Medicine and Osteopathy (Official Reports Booklet-page 83)

We urge all county medical societies to change their bylaws to admit qualified osteopaths to membership.

We recommend that the multi-level contact with the leadership of the Pennsylvania Osteopathic Association and the Philadelphia College of Osteopathy be continued.

We recommend that this report be filed for information.
Committee on Medicine and Religion (Official Reports Booklet-page 84)

We commend the work of the Committee and recommend that this report be filed for information.

Committee on General Practice (Official Reports Booklet-page 84)

We endorse the goals of the Committee in promoting general practice.

We recommend the approval of the Committee's endorsement of the preceptorship program of the Pennsylvania Academy of General Practice. We urge the county medical societies to continue to give grants of money in support of the preceptees.

We recommend that this report be filed for information.

Resolution 70-2: Tenure of Office—Delegates to the American Medical Association (Official Reports Booklet—page 147)

WHEREAS, The House of Delegates of the American Medical Association is the legislative and policy-making body of the association; and

WHEREAS, The actions of the House of Delegates exercises a strong influence on the entire medical profession of the United States and other countries; and

WHEREAS, The actions of the House of Delegates are vitally important to the maintenance and extension of high quality medical care; and

WHEREAS, It is of paramount importance that delegates to the House of Delegates of the American Medical Association have maturity and understanding of the problems and issues of the American Medical Association; and

WHEREAS, The number of members of the House of Delegates is limited and wisely so; and

WHEREAS, The House of Delegates of the American Medical Association at the 1969 Clinical Session in Denver rejected Resolution 6(C-69) limiting the tenure of delegates; therefore be it

RESOLVED, That the tenure of a delegate to the American Medical Association House of Delegates be determined by his competency, effectiveness, and value to the American Medical Association and to his constituent society.

We recommend the adoption of this resolution. (Adopted and referred to the Standing Committee on Constitution and Bylaws)

Your Reference Committee wishes to commend all the Committees submitting reports for the fine work they have done, and personally, I would like to thank the Reference Committee members and staff for their invaluable assistance.

Report of the Reference Committee on Reports of Officers

Milton S. Perloff, M.D., Chairman, presented the report of the committee which was adopted as amended.
Report of the Board of Trustees and Councilors (Official Reports Booklet—pages 15-29)

Mr. Speaker, we would like to call to your attention an error in the Report of the Board of Trustees to the 1970 House of Delegates. This error may be found on page 16 of the Official Reports Booklet under item 69-11.

The second sentence of this item reports that "subsequently a Blue Shield filing with the Pennsylvania Department of Insurance was approved resulting in expanded consultation benefits under all Blue Shield plans." In fact, the filing has not been made but it is anticipated that it will be made this week with a request for an effective date of December 1, 1970. It should be pointed out that, even if approved, that effective date will apply only for non-group subscribers and those groups paying a community rate. The expanded benefit will be made effective for Master Contract groups as their contracts are renewed.

The Reference Committee reviewed with interest the sec-

tion of the report dealing with the implementation of Resolution 69-19.

The Reference Committee is of the opinion that the current provision of 30 days for appealing an opinion rendered by the PMS Judicial Council is not sufficient considering the rather complicated work that has to be done to organize the appeal within an organized medical group. While a 30-day period is sufficient time for an individual physician who wishes to file an appeal, it is not sufficient time for a medical staff or any organized medical group to meet, discuss and formulate an appeal.

Mr. Speaker, your Reference Committee recommends that the Committee on Constitution and Bylaws be directed to amend the Bylaws changing that section dealing with the Judicial Council so that the appeal period is changed from 30 days to 60 days. (Adopted and referred to Standing Committee on Constitution and Bylaws)

Mr. Speaker, the Reference Committee also recommends that the PMS Judicial Council be requested to conclude future opinions or reports with a statement indicating the mechanism of an appeal. (Adopted)

The report of the Board is largely informational. Your Reference Committee commends the Board of Trustees for making adequate disposition of resolutions referred to it by the 1969 House of Delegates, and for the many other actions taken during the past year.

Mr. Speaker, we recommend that the report of the Board of Trustees and Councilors be filed for information.
Report of the Secretary (Official Reports Booklet—pages 30-31)

Your Reference Committee has carefully reviewed the contents of this report, which is submitted to the House as information.

Mr. Speaker, we recommend that the report of the Secretary be filed for information.
Report of the Executive Director (Official Reports Booklet—pages 31-34)

Your Reference Committee has carefully reviewed the contents of this report, which is submitted to the House as information.

Mr. Speaker, we recommend that the report of the Executive Director be filed for information.
Report of the Treasurer (Official Reports Booklet—pages 34-35)

Your Reference Committee has reviewed the report of the Treasurer. We are pleased to note the presence of a sizeable surplus for the year 1969.

Mr. Speaker, we recommend that the report of the Treasurer be filed for information.
Report of the Accountant (Official Reports Booklet—pages 35-39)

Your Reference Committee has reviewed the report of the Society's Certified Public Accountant and is pleased to note that no adverse comment was made. It is suggested that the name of the accounting firm appear in future reports.

Mr. Speaker, we recommend that the report of the Accountant be filed for information.
Reports of the Individual Trustees and Councilors (Official Reports Booklet—pages 40-65); and Supplemental Report—Ninth Councilor District

The reports of the individual Councilors are informational with the exception of a few items, one of which was referred to this Reference Committee involving a proposal contained in the report of the Eleventh Councilor District

that each District Councilor have either an executive secretary or some secretarial help provided by the State Society.

Mr. Speaker, inasmuch as the Headquarters staff is presently available for this purpose and the cost of supplying secretarial help locally to the Councilor would be prohibitive, we therefore recommend that this proposal not be approved.

The reports of the other individual Councilors and the Supplemental Report of the Ninth Councilor District do not contain any items which require action.

Mr. Speaker, we recommend that the reports of the individual Trustees and Councilors be filed for information. Model Plan for Councilor District Reorganization (Official Reports Booklet—pages 75-77)

Mr. Speaker, your Reference Committee has found little support for any "Model Reorganization Plan" and opposition to the specific plan of reorganization proposed by the Committee on Objectives. The smaller societies are concerned with the possible domination by the larger societies, while the larger societies are concerned with the possible downgrading of their relative numerical strength within the Pennsylvania Medical Society. The combinations of county societies would create regional areas of markedly unequal numbers. We concur with the objections specified by George A. Rowland, M.D., on page 53 of the Official Reports Booklet.

Your Reference Committee, while commending the Committee on Objectives for the great effort that produced this plan, feels that reorganization along the lines suggested by the Committee on Objectives is not the best way to satisfy the aims as stated by the Committee on Objectives on page 76 of the Official Reports Booklet.

Your Reference Committee, therefore, recommends that this matter be referred back to the Committee on Objectives to propose alternative methods of obtaining the five goals referred to in the Committee's report. Committee on Constitution and Bylaws (that portion dealing with SAMA Participation 8 Official Reports Booklet—page 71)

While recognizing the importance of acquainting the House of Delegates with the many activities and participation of SAMA representatives, the Reference Committee felt that the SAMA representatives, as delegates to the House, should not be singled out for special evaluation.

The Committee, therefore, recommends that the House of Delegates not approve the recommendation that the Secretary include in his annual report a brief summary of the SAMA delegates participation in the preceding annual session.

Report of the Pennsylvania Delegation to the AMA; Also its Supplemental Report (Official Reports Booklet—pages 117-119; 125-126)

The Reference Committee wishes to express its pride and pleasure in the appointment and/or election of the following members of this Society to important posts in the AMA:

Russell B. Roth, M.D.—Speaker of the House of Delegates

Elmer G. Shelley, M.D.—Chairman, Judicial Council
William A. Sodeman, M.D.—Chairman, Council on Medical Education

M. Louise C. Gloeckner, M.D.—Member, Committee on Constitution and Bylaws

William Y. Rial, M.D.,—Member, Ad Hoc Committee on Long Range Planning and Development

This Reference Committee also wishes to commend the York Hospital for being the first hospital in the nation

qualifying 100 percent of its professional staff for the AMA Physician's Recognition Award for Participation in Continuing Medical Education.

This Reference Committee noted with approval action by the AMA House of Delegates to (1) urge active membership or its equivalent for interns and residents in the State and County Medical Societies; (2) move forward with acceptance of qualified osteopathic physicians into AMA-approved training programs and specialty board examinations; (3) establish a Committee on Private Practice.

Mr. Speaker, we recommend that the report of the Pennsylvania Delegation to the AMA and the supplemental report be filed for information.

Supplemental Report B of Board of Trustees and Councilors (Official Reports Booklet—pages 122-123)

Mr. Speaker, this Reference Committee recommends approval of the Board of Trustees' recommendation to the House of Delegates that the policy of limiting the annual business and scientific meetings to locations within the Commonwealth be rescinded.

The opinions expressed to the Reference Committee with regard to the 1975 site indicated disapproval of Atlantic City as a meeting place for the Society. Mr. Speaker, your Reference Committee recommends that the Board of Trustees' recommendation that Atlantic City be the site of the 1975 meeting of the House of Delegates is rejected.

Mr. Speaker, the Reference Committee recommends that because of inadequate meeting space the House of Delegates rescind its previous action establishing Pocono Manor as the site of the 1972 annual business session.

Because the ultimate cost of the present meeting at Host Farm has not yet been ascertained, the Committee would prefer not to recommend a specific site in place of Pocono Manor.

Although under the Constitution and Bylaws this House is charged with the responsibility of selecting the site of the annual meeting, your Reference Committee believes that in this specific instance the Board of Trustees and Councilors should be authorized to select the site of the 1972 meeting of the House of Delegates.

Mr. Speaker, your Reference Committee recommends that the House of Delegates authorize the Board of Trustees to select the sites of the 1972 and 1975 Annual Business Sessions, Atlantic City excluded.

Supplemental Report D of Board of Trustees and Councilors (Miscellaneous Actions of the Board of Trustees - August, 1970 - Official Reports Booklet—pages 124-125)

Your Reference Committee has carefully reviewed the contents of this report, which is submitted to the House as information.

Mr. Speaker, we recommend that Supplemental Report D of the Board of Trustees and Councilors be filed for information.

Supplemental Report of the Judicial Council (Official Reports Booklet—pages 142-147)

Your Reference Committee has carefully reviewed the contents of this report.

Mr. Speaker, we recommend that the guidelines concerning the ethical storage and retrieval of privileged medical information in computers be approved and that they be published in PENNSYLVANIA MEDICINE and distributed to the secretary of each county medical society.

President's Address (portion dealing with PaMPAC billing)

Your Reference Committee commends Dr. Barrett on the excellent presentation of the "Structure and Services" section of his report and, in particular, his answer to what the State Society does for its individual members. Dr. Barrett's address deserves careful study by each member of the House of Delegates.

Because recommendations concerning PaMPAC dues billing appeared in both the President's and President-Elect's addresses, your Reference Committee considered them together.

The Reference Committee feels that PaMPAC is worthy of support and that experience has indicated that contributions are increased when the billing is included with the county, state and AMA dues. Therefore, we urge that all county societies list the PaMPAC billing on their dues statements with an indication that the PaMPAC contribution is voluntary.

Your Reference Committee further recommends that the components listed on the bill should be identified (i.e. AMA, PMS, county medical society and PaMPAC dues) and the grand total should include PaMPAC.

Mr. Speaker, we recommend adoption of this portion of the Reference Committee's report.

President-Elect's Address

No other specific recommendation contained in Dr. Limberger's address was referred to this Reference Committee. However, we wish to commend him for an excellent presentation of the problems facing him in his coming administration and for the solutions that he proposes.

Resolution 70-15—Definitive Interpretation of "Sole Arbitrator" Principle

WHEREAS, The Judicial Council of the Pennsylvania Medical Society, after a hearing in Philadelphia on January 10, 1969, rendered an opinion which said: "It is ethical for a medical staff to adopt a resolution which requires all members of a staff to donate a percentage of third party payments to a hospital fund, educational fund, teaching fund, etc.." and in the same opinion, it added, "It is important, also, to remember that your council continues to recognize that the physician is, in the final analysis, the sole arbiter of his income, for, if a physician is unwilling to support such a fund when same is established by a majority vote of the medical staff, he can, as a matter of absolute right, relocate..."; and

WHEREAS, The House of Delegates of the Pennsylvania Medical Society, meeting in October 1969, adopted Resolution 69-19 which reaffirmed a 1967 Resolution of the House of Delegates which stated that an individual physician may not be deprived of his right by a vote of a medical staff or medical board of a hospital to be the "sole arbiter" of the disposition of his professional income, and also adopted in Resolution 69-19 the statement that the House of Delegates disagrees with the Judicial Council's interpretation of the AMA guidelines as they pertain to the right of an individual physician to be the sole arbiter of the disposition of his professional income; and also adopted the statement that "the House of Delegates, Pennsylvania Medical Society, strongly recommends that the Judicial Council reconsider its interpretation of these guidelines and issue its opinion at the earliest possible date."; and

WHEREAS, A letter to Park M. Horton, M.D., Chairman, Board of Trustees, Pennsylvania Medical Society from the Chairman of the Judicial Council of the Pennsylvania Medical Society, dated February 4, 1970, states, "Resolution 69-19 makes only a recommendation (which is as much as it can do in this particular instance), that is not controlling on the Council. Your Council respectfully

declines at this time to reconsider its prior opinion on the substantive matter referred to in the Resolution 69-19..."; therefore be it

RESOLVED, That the House of Delegates, Pennsylvania Medical Society submit a request to the Judicial Council of the AMA for a more definitive interpretation of the AMA guideline as it pertains to the area of "sole arbiter" of the disposition of his professional income.

Your Reference Committee feels that implementation of this resolution will lead to a clarification of the issues involved.

Mr. Speaker, your Reference Committee recommends that Resolution 70-15 be adopted.

Report of the Reference Committee on Miscellaneous Business

Richard I. Darnell, M.D., Chairman, presented the following report of the committee which was adopted as amended by the House.

RESOLUTION 70-12: Application to Medical Staffs (Official Reports Booklet—Page 150)

WHEREAS, Qualified physicians may not be given the opportunity to apply for medical staff membership at certain hospitals because of bylaws which state "the application shall originate with the Director of a Staff Department," therefore be it

RESOLVED, That the Pennsylvania Medical Society recommend that any physician who is qualified to be a member of a particular county medical society in Pennsylvania shall be afforded the privilege to file an application to the medical staff of any hospital in that county; and be it further

RESOLVED, That such application shall be acted upon by the Credentials Committee of that hospital within a reasonable time.

Your committee sympathizes with the intent of this resolution. However, it offers no effective redress to the aggrieved physician who finds himself rebuffed in his quest for privileges at a particular hospital. Each accredited hospital has bylaws adopted in detail for a variety of reasons, good or less so, by the staff of that particular hospital and subject to review by the Joint Commission on Accreditation. In the normal procedure action on an application for privileges includes reasonably prompt evaluation by the Credentials Committee of the staff. Your committee fails to find merit in this resolution and recommends rejection.

The House disagreed with the Reference Committee on Miscellaneous Business and Resolution 70-12 was adopted.

RESOLUTION 70-13: Identification of Authors of Resolutions Presented to Pennsylvania Medical Society House of Delegates (Official Reports Booklet—Page 150)

WHEREAS, The present rules of the House of Delegates of Pennsylvania Medical Society require that resolutions presented carry the name of the secretary of the county society of the originator; and

WHEREAS, The original author has more knowledge of the subject area of the resolution and may be sought for additional information and comment concerning the resolution; now therefore be it

RESOLVED, That the rule of procedure of this House be amended to permit the name and identity of the authors of resolutions to be included with the resolution in the Delegates Handbook.

Your committee recommends rejection as this resolution requires no change in Rules of Procedure of this House. See Standing Rule No. 2, "Procedure for Submitting Resolu-

tions," revised October 10, 1962, as published in the Delegates' Handbook of 1970. A memorandum to staff personnel would be a simple solution, identifying the author of a resolution as well as the component society from which it emanated.

Reference Committee on Public Service

Hunter S. Neal, M.D., Chairman, presented the following report of the committee which was adopted as amended by the House.

Introduction, Report of the Council on Public Service (Official Reports Book—Page 96)

Recommendation K, Address of Dr. Barrett (Appendix C)

Comment H, Address of Dr. Limberger (Appendix D)

The Council is pondering whether its limited funds should be used to emphasize public or professional communications. Dr. Barrett suggests that the Council have the benefit of the thinking of the House. However, the Reference Committee feels that such advice would be premature until more specific information is available and feels that a professionally designed and implemented survey of the attitudes and opinions of Pennsylvania physicians could provide much of the information for the guidance, not only of the Council, but of the entire Pennsylvania Medical Society. We recommend that such a survey be considered as soon as funds can be made available, and that the current emphasis on public communications be continued until the survey is evaluated.

This portion of the reference committee report was filed.

Dr. Limberger's comments on communications provide an excellent presentation of the many problems involved and we recommend that they be referred to the Council on Public Service.

Health Careers Recruitment (Official Reports Book—Page 102)

The Reference Committee recognizes that the Council is conducting a successful program promoting health careers, and it recommends that more efforts be directed toward encouraging students from disadvantaged areas to enter the field.

This portion of the report was filed.

Students, Interns and Residents (Official Reports Book—Page 103)

Opinion Survey of Medical Students

Supplemental Report E of the Board of Trustees and Councilors (Appendix B)

Cognizant of current budget limitations, we recommend that the survey of medical student attitudes—valuable though we feel it would be—not be conducted at this time.

However, we believe the socio-economic course for interns and residents can fill a need that it is essential to meet. The Board has deleted funds for its continuance in 1971. In our only recommendation involving additional funding, we recommend that the funds requested (\$1,000) be restored if it is at all possible to do so.

The House approved the recommendation of the reference committee, to restore the \$1,000 for a socio-economic course for interns and residents, if at all possible.

The Reference Committee recognizes that there is a proven value to the type of preceptorship program operated by the Student American Medical Association in Appalachia last year, and recommends that the House of Delegates endorse the concept of preceptorships as a means of solving the maldistribution of medical care.

Remainder of the Report of the Council on Public Service (Official Reports Book—Pages 97-106)

The Reference Committee congratulates the Council for its wide variety of well-implemented activities within a limited budget. Every program of the Council serves a good purpose. The Committee is impressed, especially by such things as the cooperation with the Pennsylvania Federation of Women's Clubs in the drug abuse program. We recommend that the Council try to develop similar cooperation with other worthy organizations.

This portion of the reference committee report was filed with the Council on Public Service.

County Society Award

Report of the Fourth District Trustee and Councilor (Official Reports Book—Page 52)

It is good to recognize outstanding public service activities by county medical societies, but such recognition has its greatest value when it is generated from outside of the profession. However, having physicians congratulate physicians does have professional relations value, and we recommend that the proposal be referred to the Council on Public Service for consideration at such time as funds may be available for such a project.

Recommendation F, Address of Dr. Limberger (Appendix D)

The Reference Committee is in sympathy with the people and physicians of Perry County in their efforts to establish a West Perry Clinic and commends O.K. Stephenson, M.D., for his outstanding leadership, but, recognizing the financial involvement, concluded it would be unwise to divert funds to conduct a survey at this time. We recommend, however, that the State Society provide all possible non-financial support to the West Perry Clinic Corporation.

Resolution 70-14: Noise Pollution

WHEREAS, It has been shown that noise above a certain level has a deleterious effect upon hearing and may have an unfavorable effect on general health; and

WHEREAS, There are implements commonly used such as lawn mowers, power saws, etc. that produce noise levels above a safe point; now therefore be it

RESOLVED, That the Pennsylvania Medical Society encourage the initiation of legislative and educational measures to notify purchasers of these implements of their potential dangers and how these dangers might be minimized; and be it further

RESOLVED, That those responsible for entertainment at meetings of the Pennsylvania Medical Society be directed to provide entertainers whose decibel production is well below a hazardous level.

Noise pollution is only a component of the much larger environmental problem, and as such, we feel it deserves to be included in consideration of the total problem. Therefore, we recommend that the resolution be referred to the appropriate State Society body for inclusion in the implementation of specific environmental programs.

Concerning the second resolve, the Reference Committee had a rare opportunity for immediate action. Decibel meter measurements were taken at last night's State Dinner. You were safe—and delightfully so, thanks to Marcia Gehris.

Resolution 70-22: Drug Abuse (Second Resolve)

WHEREAS, Drug abuse has become a problem of epidemic proportions among the youth of our nation; and

WHEREAS, Adequate study and research of the safe long-term use of some commonly abused drugs has not been made; and

WHEREAS, Laws of the Commonwealth pertaining to the illegal possession, sale, and use of drugs have been inconsistent; and

WHEREAS, Efforts to educate the public by various organizations throughout the Commonwealth have often been ineffective due to lack of coordination of effort among these organizations; therefore be it

RESOLVED, That the Pennsylvania Medical Society through the Council on Governmental Relations use its influence and lend its support to efforts to bring about revision of the laws pertaining to drug abuse to a point where they are viable, enforceable, and consistent; and be it further

RESOLVED, That the Pennsylvania Medical Society take the lead in developing a well-coordinated, effective educational program bringing together, as much as possible, the many groups now presently making a contribution to this vast educational effort.

The Department of Health already is attempting to coordinate drug education activities. Therefore, the Reference Committee recommends that the second resolve in Resolution 70-22: Drug Abuse, be revised as follows: "RESOLVED, That the Pennsylvania Medical Society assist the Commonwealth of Pennsylvania in developing a well-coordinated, effective educational program bringing together, as much as possible, the many groups now presently making a contribution to this vast educational effort." We recommend adoption of Resolution 70-22 as amended.

Resolution 70-23: Bicentennial of the Independence of the United States of America

WHEREAS, The President of the United States has declared that Philadelphia, Pennsylvania shall be the focal point of the Bicentennial of the Independence of the United States of America; and

WHEREAS, The basic theme of such a celebration is to be cultural and social rather than commercial; and

WHEREAS, the contributions to world medicine from the Commonwealth of Pennsylvania in general and Philadelphia in particular, have been in great evidence over two centuries; and

WHEREAS, the American Medical Association, the Philadelphia County Medical Society, and many other medical and scientific societies are formulating plans for the participation in such observances; therefore be it

RESOLVED, That the President of the Pennsylvania Medical Society and the Board of Trustees be urged to support all medical activities relevant to the Bicentennial celebration in Philadelphia, in order that these groups may cooperate in every possible way in developing plans to display the past, present and prospective aspects of all health-related services; and be it further

RESOLVED, That the Pennsylvania Medical Society give whole-hearted endorsement to the Bicentennial celebration and to the extending of invitations to national and international societies that have not already done so to participate in the celebration; and be it further

RESOLVED, That the Board of Trustees of the Pennsylvania Medical Society consider means and make recommendations for the necessary funding and implementation of such plans as may be endorsed by this society; and be it further

RESOLVED, That the services of the Pennsylvania Medical Society be offered to the official Bicentennial organization and its appropriate committees; and be it further

RESOLVED, That notification of this action be made to the President of the United States, the Governor of the Commonwealth of Pennsylvania, and the Mayor of Philadelphia and all other concerned public officials.

The State Society already is considering what its role in the bicentennial celebration should be, and this resolution should assist it in reaching a decision. However, we recommend the third "resolve" be amended for clarity as follows: "RESOLVED, That the Board of Trustees of the Pennsylvania Medical Society consider means, funding and implementation of such plans as may be instituted by this Society. We recommend adoption of Resolution 70-23 as amended.

In conclusion, the Reference Committee points out that its deliberations were adversely influenced by the Society's budgetary restrictions which made it difficult for your Reference Committee to fulfill its complete responsibilities.

The House recessed at noon for lunch and balloting. It was agreed to reconvene at 1:30 p.m. During the noon recess, delegates presented themselves to the Credentials Committee, located in the La Fonda Lounge, at which time they received their ballot. Tables and chairs were placed in the La Fonda Lounge for the convenience of the voters and the ballot box manned by the tellers was also located in the La Fonda Lounge. Upon the reconvening of the House at 1:40 p.m., the polls were closed by the Speaker.

**Report of the Reference Committee on
Education and Science**

James B. Donaldson, M.D., Chairman, presented the following report of the committee, which was adopted as amended by the House.

Report of Council on Education and Science (Official Reports Booklet—pages 106-117)

The Reference Committee has reviewed in detail the many activities of this Council during the past year. It is evident that the members of the Council have been diligent in their efforts to advance the programs of education and science. We mention several items which we believe deserve your special attention.

The Council has reported on its activities in organizing hospital-based educators. We commend the Council for these activities and believe that future programs should include preparation of guidelines that would coordinate the activities for this very important group.

We noted with great interest the report regarding the PMS-POA Seminar and are pleased to note the success of this cooperative venture. We heartily endorse the Council's expansion of such programs.

The success of the 1969 Scientific Assembly has led the Council to develop more innovative programs for the 1970 Assembly. We endorse this type of continuing education and encourage its continuation.

It is enlightening to see the report regarding the community hospital courses. These are serving their primary function of reaching physicians in areas somewhat remote from teaching centers. The Reference Committee urges continuing of this program.

Much activity has been reported regarding emergency medical services. Such services certainly are here to stay and much more information and training should be made available to the members of the State Society. We are pleased to note that the Council expects to publish a "white paper" on this subject. Each member of the House is urged to watch for this publication and use it as a basis for future emergency medical service programs.

The list of Council priorities for 1970-71 gives an overall picture of the Council's hopes for the new year. This Committee commends them to your reading.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Resolution No. 70-11: First Aid Training for High School Students (Official Reports Booklet, page 150)

WHEREAS, Emergency first aid and resuscitation are important elements in the initial care of victims of accidents and medical emergencies; and

WHEREAS, The lay person on the scene may be able to save a life or prevent further injury by application of first aid principles; and

WHEREAS, There is no required educational program for such training; now therefore be it

RESOLVED, That all high school students be offered a first aid course similar to the American Red Cross Standard Course or the Civil Defense Medical Self Help Training Course prior to graduation from high school.

The Reference Committee concurs with the objectives of this resolution. Mr. Speaker, I recommend the adoption of Resolution No. 70-11.

Resolution No. 70-16: Commitment Under Mental Health/Mental Retardation Act

WHEREAS, The purpose of the Mental Health and Mental Retardation Act of 1966 is to make it possible for every person with a mental disability to receive the kind of treatment he needs, when and where he needs it; and

WHEREAS, Restrictions placed upon the usage of certain portions of the Act, specifically Section 404 (permitting the commitment of a protesting patient on the signature of two physicians upon the petition of an interested third party), by the Attorney General's office based upon their interpretation of the current legal climate, have interfered with the realization of the stated purpose of the Act; and

WHEREAS, Because of these restrictions, physicians, community mental health centers, hospitals, and other agencies charged or dedicated to assisting the mentally disabled are increasingly unable to fulfill their obligations; and

WHEREAS, Undue hardships, financial, emotional, and otherwise, have been placed upon families, physicians, and hospitals; and

WHEREAS, Urgent treatment of the patient has been unnecessarily delayed, causing possible deleterious effects and regression of the patient, due to extensive legal procedures required to commit a protesting patient as a result of these restrictions; therefore be it

RESOLVED, That the Pennsylvania Medical Society strongly recommend to the Attorney General that Section 404 again be literally interpreted in accordance with its original intent to permit a protesting patient to be committed on the signatures of two physicians; and be it further

RESOLVED, That the right of the patient to immediate, effective treatment be emphasized while assuring that the civil rights of the patient are adequately protected.

The Reference Committee concurs with the objectives of this resolution, which seeks to serve the best interests of patients and the public by requiring only two physicians' signatures for commitment.

Mr. Speaker, I recommend the adoption of Resolution No. 70-16.

Board Supplemental Report A: Licensed Practical Nurse Act (Official Reports Booklet—page 121)

Your Reference Committee is in agreement with the in-

tent of the recommendations in the supplemental report. Testimony before this Committee has led us to conclude that there is need for further but urgent study regarding the high school diploma as a valid credential for entrance into Licensed Practical Nurse training programs. The Committee is of the opinion that some form of nurse training can be instituted through the vocational-technical high schools in the Commonwealth. It seems reasonable that credit for training at the high school level could be applied or accepted as fulfilling part of the requirements in LPN or RN programs. It seems reasonable that academic study could be instituted at the twelfth grade level with clinical training being undertaken as a post high school subject. Consideration should be given to starting the career-ladder approach for nurses' training in the high school.

We cannot approve the recommendation of Supplemental Report A removing the requirement of the high school diploma in the Licensed Practical Nurse Act. We recommend that this Society meet with appropriate representatives of the nursing profession to review the concept that we have outlined above and to arrive at a practical solution of utilizing the vocational-technical schools in basic nursing education. We also recommend that the Board of Trustees be empowered to act to introduce legislation to change the requirements of the Licensed Practical Nurse Act if so recommended by the special study committee.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Report of Council on Education and Science: Production of Physicians (Official Reports Booklet, page 108)

Encourage Medical School Expansion (President's Address, Recommendation A; Appendix C Address of President-Elect, Recommendation B1 Appendix D)

There is need in Pennsylvania to increase the physician output from Pennsylvania medical schools. The action of the Council and the Board of Trustees with regard to the production of more physicians is an excellent step forward. We would, however, point out the fallacy in the present proposal of financial support which limits eligibility to Pennsylvania residents if the purpose is to guarantee that these students will practice in the Commonwealth of Pennsylvania.

We would heartily endorse the recommendations of the President and President-Elect regarding medical school expansion.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Allied Health Personnel (President's Address, Recommendation B, Appendix C, Address of President-Elect, Recommendation E, Appendix D)

The Committee approves these two separate recommendations, both of which would allow increased use of allied health personnel.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Curriculum for Primary Physicians (Address of President-Elect, Recommendation C1, Appendix D)

This Committee approves the objectives of the President-Elect to develop a basic plan of study at medical schools for primary physicians. We believe that the matter should be referred to the Committee on General Practice for further consideration and implementation.

Mr. Speaker, I recommend approval of this portion of the Reference Committee report.

Medical Education, Including Non-Technical Aspects of Health Care (Address of President-Elect, Recommendation C2, Appendix D)

We approve the President-Elect's recommendation that medical education should be more relevant to the social needs of citizens. Your Reference Committee feels that students should be informed about socioeconomic aspects of medicine leading to a wider base for health services. It is recommended that each SAMA chapter be asked to designate a representative to meet with an appropriate PMS committee to develop a specific program for implementation and submission to medical schools.

Mr. Speaker, I recommend the approval of this portion of the Reference Committee report.

Development of Self-Assessment Examinations (Address of President-Elect, Recommendation D1, Appendix D)

We approve this recommendation. In addition, we believe it is important that the Pennsylvania Medical Society should insure the availability of these tests to all physicians in the state whether or not they are members of specialty organizations.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Board Supplemental Report E, Appendix B; Resolution No. 70-24—Meeting on the Clinical Aspects of Geriatric Medicine Prior to the White House Conference on that Subject Introduced by: Board of Trustees and Councilors

WHEREAS, Experience at two previous sessions of the White House Conference on the Aging, held ten years apart in Washington, D.C., has indicated that welfare departments have been energetic and efficient in promoting individual welfare-oriented state plans; and

WHEREAS, These White House Conferences are structured in such a fashion that clinical needs do get presented but usually in a way that tends to make primary health aspects of aging citizens subservient to sociological problems, economic considerations, nursing home requirements and the like; and

WHEREAS, A strong medical approach to public health and personal health of the elderly needs to be emphasized at this important session; and

WHEREAS, A consensus is sorely needed by which state medical society groups can adjust their relationships to governmental agencies in order to ensure medically-oriented action and to influence decisions; therefore be it

RESOLVED, That the American Medical Association or a state medical society, with the cooperation of the services of the American Medical Association, call a meeting immediately prior to the White House Conference (scheduled for November 1971) of all state medical society chairmen of geriatrics, or their counterparts, to prepare a statement on the clinical aspects of aging to be submitted as part of the record of the 1971 White House Conference.

The Reference Committee concurs with the intent of the resolution. We offer the following amended resolution which defines the responsibility for implementation.

RESOLVED, That the American Medical Association and the Pennsylvania Medical Society call a meeting immediately prior to the White House Conference (scheduled for November 1971) of all state medical society chairmen of geriatrics, or their counterparts, to prepare a statement on the clinical aspects of aging to be submitted as part of the record of the 1971 White House Conference.

RESOLVED, That the Pennsylvania delegation be instructed to introduce this resolution at the AMA House of Delegates' 1971 Clinical Session.

Mr. Speaker, I recommend the adoption of this amended Resolution No. 70-24.

Continuing Education Institute (Board Supplemental Report E, Appendix B; President's Address, Recommendation D1, Appendix C; Address of President-Elect, Recommendation D2, Appendix D)

Your Reference Committee recognizes that an institute concept is a logical way to have an on-going program which can reflect the continuing education needs of Pennsylvania physicians. This Committee approves the recommendations of the Board of Trustees and the President-Elect. We believe the recommendation contained in the address of the President should be referred to the Council on Education and Science for further consideration.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Continuing Education Membership Requirement (Supplemental Report, Council on Education and Science, Appendix E; Board Supplemental Report E, Appendix B; President's Address, Recommendation D2, Appendix C, Address of the President-Elect, Recommendation D3, Appendix D)

Your Reference Committee is in full sympathy with the principle of a continuing education membership requirement. We feel that the proposals presented by the Council, the President, and the President-Elect will have a better chance for acceptance by the membership if action is postponed until the Continuing Education Institute concept is more fully developed; therefore, we recommend no actions on these proposals at this time.

We approve of the philosophy of the Board of Trustees as outlined in Supplemental Report E.

Mr. Speaker, I recommend the adoption of this portion of the Reference Committee report.

Following an extended discussion it was moved and seconded that the House adopt the recommendation of the Council on Education and Science, regarding a continuing education membership requirement, as outlined in the Council's Supplemental Report (Appendix E). That recommendation follows:

"This Council, therefore, recommends that this House of Delegates, as the policy-making body of this Society, not entertain thoughts of periodic relicensure but rather require all of the active members to qualify for the AMA Physician's Recognition Award in order to retain membership in the Pennsylvania Medical Society. The recommended effective date for this membership requirement would be July 1, 1972 (three year qualifying period commences) which would coincide with the beginning of a yearly-qualifying period established for the AMA Physician's Recognition Award. It is further recommended that the Committee on Constitution and Bylaws be requested to prepare the necessary amendments to implement this and present them to this House of Delegates. Similar action on the part of each component county medical society is urged."

The House adopted the above recommendation and referred it to the Standing Committee on Constitution and Bylaws for implementation. (The entire supplemental report of the Council on Education and Science is included as Appendix E)

Mr. Speaker, your Reference Committee appreciates the interest and advice given by physicians and others during the open hearing. It was a special privilege for your

chairman and the other physicians on the Reference Committee to have one of the SAMA delegates serve as a member of this Committee. His counsel was both helpful and refreshing.

Mr. Speaker, I recommend the adoption of the report of the Reference Committee on Education and Science as a whole as amended.

It was moved and seconded that the specific requirements of the AMA Physician's Recognition Award be reviewed by the Council on Education and Science and adjusted appropriately in line with the needs of the Pennsylvania Medical Society. This motion was carried.

PaMPAC Presentation

William B. West, M.D., Chairman of the PaMPAC Board of Directors, presented an informational report to the House. Dr. West's remarks are attached as Appendix F.

Report of the Reference Committee on Medical Service

John L. Steigerwalt, M.D., Chairman, presented the following report of the committee which was adopted by the House as amended.

Report of the Council on Medical Service (Official Reports Booklet—Pages 89-96) and Supplemental Report A of the Council on Medical Service (Official Reports Booklet—Pages 129-139)

The Council has been diligent in carrying out liaison responsibilities with Blue Shield and is to be commended for its efforts.

Resolutions 68-5; 68-28; 68-29: Provision of an Adequate Concurrent and Consecutive Care Program by Pennsylvania Blue Shield

The 1969 House of Delegates referred these Resolutions to the Council on Medical Service to follow-up with Blue Shield on their implementation. Your Reference Committee is pleased to report that these Resolutions have been implemented by Blue Shield effective February 1, 1970.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report. Blue Shield Plan A

Your Reference Committee reviewed the statistical report which outlined the decline in enrollment of subscribers under Blue Shield Plan A. Blue Shield has made a reasonable effort to phase out Plan A, particularly in view of the fact the Commonwealth's Insurance Commissioner requires that Plan A be maintained for those subscribers who meet the income requirements. Blue Shield should continue its efforts to encourage Plan A subscribers to up-grade their coverage.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report. Pennsylvania Blue Shield Report to House of Delegates (Available on request)

Your Reference Committee has carefully perused the report to the House of Delegates from Pennsylvania Blue Shield and is pleased to learn of the continued growth of Pennsylvania Blue Shield and to hear of the progress being made in claims processing and of other Blue Shield activities. Blue Shield should be encouraged to continue its development of plans which will meet the rapidly changing health care needs of the future.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Prevailing Fee Program

Your Reference Committee commends the Council for its efforts in guiding Blue Shield in the development of the Prevailing Fee Concept to allow payment of differential fees with reasonable control mechanisms.

Your Reference Committee felt it should be noted that there is considerable misunderstanding on the part of physicians between the service benefit concept and an indemnity insurance program. Efforts should be made by the Society and by Blue Shield to clarify the distinction between the two since the difference is basic in the understanding of the Prevailing Fee concept.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report. Blue Shield Participating Doctor Agreement

Your Reference Committee concurs with the Council's recommendation and the action taken by the Board of Trustees regarding the new Participating Doctor's Agreement. The House of Delegates should take particular notice of the factors outlined in the Council's report on which the action of the Board of Trustees was based.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report. Blue Shield Guidelines for Prepaid Group Practice

Your Reference Committee concurs with the Council's recommendation and the subsequent action taken by the Board of Trustees. However, the Reference Committee felt that it is of utmost importance that it be noted that the action of the Board of Trustees found the guidelines acceptable and this should not be construed as an action to exclusively support or approve the prepaid group practice concept since many of our members practice in areas where neither group practice nor prepaid group practice is feasible. Any action related to the development of prepaid group practice through Blue Shield without recognition of physicians who do not practice in a group may place these physicians in a disadvantageous position.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Recommendation Three of the Committee on General Practice (Official Reports Booklet—Page 85)

In considering Recommendation Three of the Committee on General Practice, your Reference Committee noted that the Committee's recommendation that group practice be endorsed as a preferred method of delivering health care was based on the premise that group practice seems to be a more efficient method of delivering health care. The Reference Committee did not feel sufficient information had been presented to clearly demonstrate that group practice is, in fact, a more efficient method of delivering health care in all settings. To approve the Committee's recommendation could lead to an inference that physicians in solo practice are delivering health care inefficiently. The evidence available does not necessarily support such a statement. Your Reference Committee recognizes that in certain situations a physician may elect to practice in an area due primarily to the fact there is an established group with which he can associate. However, the Reference Committee agreed that there were many other factors that enter into a physician's decision as to where he will locate. Furthermore, in view of the fact it is the individual physician's decision to determine where he will practice, it does not seem reasonable or advisable to endorse group practice as the preferred method of delivering health care.

Mr. Speaker, your Reference Committee recommends

that Recommendation Three of the Committee on General Practice not be approved by the House of Delegates.

Meeting with Steel Industry

Your Reference Committee commends the Council for maintaining liaison with management and union officials of the Steel Industry and urges the Council to pursue this activity as it deems appropriate.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Pennsylvania Blue Cross Plans

Your Reference Committee approves of the efforts of the Council in the development and functioning of regional Blue Cross Medical Advisory Committees. However, it was the feeling of the Reference Committee that the Council's activities have been more extensive in Western Pennsylvania and efforts should be directed to expanding the Western Pennsylvania Programs to all Blue Cross Plans in the state.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Western Pennsylvania PMS - Blue Cross Regional Steering Committee.

Your Reference Committee was impressed with the activities of the Western Pennsylvania PMS - Blue Cross Regional Steering Committee and recommends that similar steering committees be organized for each Blue Cross Plan.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Pennsylvania Medical Society Review Program and Section of Second Councilor District Annual Report Regarding Second Councilor District Physicians' Advisory Committee (Official Reports Booklet—Page 48) and Recommendation G, Address of the President-Elect—Peer Review (Appendix D)

Your Reference Committee believes the Society's revised Review Program has greatly improved the Society's capacity for handling disputed fee cases and utilization problems presented by third party carriers. However, the Reference Committee felt the Council's report requires clarification so that it is understood that the Review Program is designed primarily to evaluate disputed fee cases and utilization problems involving physician services and does not review hospital utilization cases since this function is carried out by the individual hospital utilization review committees and the Blue Cross Medical Advisory Committees.

Your Reference Committee agreed that the recommendation of the President-Elect regarding peer review is consistent with the objectives of the Society's Review Program.

Your Reference Committee approves of the actions taken by the Second Councilor District Physicians' Advisory Committee to revise the policy and procedure followed by the Second Councilor District Review Committee.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Medicare and Recommendation H of the Address of the President (Appendix C)—Prepaid Insurance Programs and Social Security Administration; and a portion of Supplemental Report E of the Board of Trustees (Appendix B)

The Council should be commended for developing effective liaison with the Social Security Administration Bureau of Health Insurance and should be urged to continue discussions with the Bureau of Health Insurance to seek further improvements in the Medicare Program.

Your Reference Committee commends the Council for documenting several Medicare claims processing problems and making recommendations for improvements to Blue Shield. The Blue Shield implementation of the recommendations appears reasonable and Blue Shield should be commended for seeking the advice of the Pennsylvania Medical Society in resolving these problems.

Your Reference Committee concurs with the Board of Trustees' approval of the following statement, adapted from a position recommended by the Pennsylvania Academy of General Practice:

"The Pennsylvania Medical Society favors the creation of a properly constituted and representative Physician Board of Review to be included in the Medicare utilization review and appeal procedure for extended care facilities."

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Pennsylvania Department of Public Welfare Recommendation F of the Address of the President (Appendix C)—Council on Medical Service; and Supplemental Report E of the Board of Trustees (Appendix B)

Although there have been no significant improvements in the Commonwealth's Medical Assistance Program during the past year, your Reference Committee believes the Council has been successful in developing a more cooperative relationship with the Department of Public Welfare. Hopefully, the improved liaison will result in achievement of some of the objectives outlined in the Council's report. Your Reference Committee recommends that the Council be urged to continue its efforts to seek improvements in the Medicaid Program, the Hill-Burton Program, and to provide guidance in the development of new hospital licensing regulations. In making this recommendation, your Reference Committee recognizes that it is the ultimate goal of the Society to have all health related programs presently in the Welfare Department transferred out of the Department in accordance with the Society's recommendations for reorganization of the Commonwealth's Health and Welfare Departments.

Your Reference Committee believes that the recommendation of the President regarding underwriting of the Medical Assistance Program is consistent with present Society policy.

Your Reference Committee concurs with Supplemental Report "E" of the Board of Trustees regarding the statement related to fees for physicians under the Medical Assistance Program.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Commission on Comprehensive Health Planning

Your Reference Committee reviewed the summary of the survey conducted by the Commission to determine the extent of physician participation in Regional Medical Programs and Comprehensive Health Planning activities. Your Reference Committee concluded, after reviewing the survey results, that there is considerable confusion and misunderstanding on the part of county medical societies regarding

RMP and CHP activities. Your Reference Committee recommends that the Commission on Comprehensive Health Planning make every reasonable effort during the next year to improve physician understanding of these two governmental programs which will, hopefully, improve physician participation.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Society Endorsed Group Insurance Programs and Recommendations G1 and 2 of the Address of the President (Appendix C)—Prepaid Insurance Programs

Your Reference Committee commends the Council for its efforts to improve the group insurance programs available to our membership. It was noted that the Council made improvements in the Disability Income Plan as well as adding a Group Life Insurance Program and a Professional Business Overhead Expense Plan. Your Reference Committee urges the continuation of these activities.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Malpractice Insurance and Recommendation I of the Address of the President-Elect (Appendix D)—Litigation and Insurance for Medical Liability

Although the malpractice insurance climate has not improved substantially during the past year, the Council has made every reasonable effort to improve the situation. Your Reference Committee noted the Council is still considering a Group Malpractice Insurance Program for the membership. The House of Delegates should note the several points outlined in the Council report that must be considered in the development of a group program. The Council should proceed with caution to assure the development of a sound program in view of the many adverse conditions at the present time. Your Reference Committee is concerned with the increased severity of the problem in certain areas of the state and urges every effort be exerted to find a solution.

Your Reference Committee agrees that the recommendation in the President-Elect's Address regarding litigation and insurance for medical liability is consistent with the objectives of the Councils on Governmental Relations and Medical Service.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

Supplemental Report B - Council on Medical Service (Official Reports Book—Pages 139-142) and Recommendation of the Address of the President (Appendix C)—Foundation for Medical Care

Your Reference Committee received extensive testimony supporting the concept of a Medical Care Foundation. Your Reference Committee was impressed with the ultimate potential such a concept offers. Your Reference Committee commends the Council on Medical Service for its initiative in developing this concept. Your Reference Committee recommends that the House of Delegates approve the concept of a Medical Care Foundation and direct the Council on Medical Service to proceed with the development of a program to be presented at the next meeting of the House of Delegates.

Recommendations F, 1 and 2 of the Address of the President-Elect (Appendix D)—Delivery of Health Care

Your Reference Committee supports the concept embodied in the President-Elect's recommendation related to the delivery of health care and recommends that this portion of the address be referred to the appropriate body of the Society for study and recommendation.

Mr. Speaker, your Reference Committee recommends approval of this portion of the Reference Committee report.

RESOLUTION 70-3: Blue Shield New Doctor Profiles (Official Reports Book—Pages 147-148)

WHEREAS, The latest regulations from Blue Shield require that they have one year's experience with a fee increase before they will start reimbursement at the increased fee; and

WHEREAS, This requires any physician to notify his patients one year prior to increasing fees; and

WHEREAS, This requires any physician to put an increased fee on his third-party reports for one full year before the third-party will recognize the fee increase; therefore be it

RESOLVED, That the Pennsylvania Medical Society notify Blue Shield that it is dissatisfied with such a proposal and that it should return to the previous plan of three months prior notification to Blue Shield for fee increases; and be it further

RESOLVED, That the Pennsylvania Medical Society representatives on Blue Shield's official boards work diligently toward accomplishing the intent of this resolution.

Your Reference Committee heard testimony indicating concern over the procedure to be adopted regarding the recalculation of usual charges under the Prevailing Fee Program. Your Reference Committee was advised that Pennsylvania Blue Shield will initiate a comparative analysis starting on January 1, 1971 in an effort to develop the most equitable procedure for determining the time period for recalculation of an individual physician's usual charge. In view of this development, your Reference Committee does not feel it advisable to recommend approval of Resolution 70-3.

Mr. Speaker, your Reference Committee recommends that Resolution 70-3 be rejected.

RESOLUTION 70-7: Deletion of the Term "The Doctor's Plan" from Blue Shield Vocabulary (Official Reports Book—Page 149)

WHEREAS, The Blue Shield Plan is advertised as "The Doctor's Plan;" and

WHEREAS, All of the physicians in the State of Pennsylvania do not belong to the Blue Shield Plan, nor do they necessarily approve of the Blue Shield Plan or its management; and

WHEREAS, Coercion of physicians by the Blue Shield Plan exists due to the fact that membership in the Blue Shield Plan is obligatory in order to collect Blue Shield fees; therefore be it

RESOLVED, That the Pennsylvania Medical Society enjoin, and if necessary, resort to legal measures to have the Blue Shield Plan cease and desist calling itself "The Doctor's Plan" in its advertising and literature.

Your Reference Committee received overwhelming testi-

mony endorsing Pennsylvania Blue Shield as being representative of "The Doctor's Plan."

Mr. Speaker, your Reference Committee recommends rejection of Resolution 70-7.

RESOLUTION 70-8: High Level Income Ceiling - Blue Shield Prevailing Fee Plan (Official Reports Book—Page 149)

WHEREAS, The fee payments as proposed by Pennsylvania Blue Shield under the prevailing fee schedule are independent of the level of income of the subscribers; and

WHEREAS, It is not completely understood among the members of the medical profession as to how terms "usual, customary and prevailing fee" are to be construed and also exactly what is the base on which the "90 percentile" will be calculated and how often this base will be reviewed; and

WHEREAS, The principle involved seems to ignore the differences in the individual patient's demands and individual physician's expertise; and

WHEREAS, A physician who accepts the care of a highly productive, high income patient also accepts a greater responsibility, and thus compensation should properly be increased; therefore be it

RESOLVED, That the Medical Society of the State of Pennsylvania recommend to the Board of Directors of Pennsylvania Blue Shield, Inc. and the State Insurance Commissioner that an income ceiling at a relatively high level be introduced so that the participating physician would not be restricted by the prevailing fee principle in the case of family units above this income level.

Based on the testimony received, your Reference Committee felt there is merit in the intent of the Resolution but that it should be studied and further developed by the Council on Medical Service.

Mr. Speaker, your Reference Committee recommends that Resolution 70-8 be referred to the Council on Medical Service for study and recommendation.

The House disagreed with the recommendation of its Reference Committee and rejected Resolution 70-8.

RESOLUTION 70-9: Establishment of Official Peer Review Committees (Official Reports Book—Page 149)

WHEREAS, The vast majority of physicians are honorable, fair-minded individuals who maintain the highest ethical standards; and

WHEREAS, An increasingly greater percentage of the medical professions's income is coming from third party payments including the Federal Government; and

WHEREAS, A small number of physicians have been accused of having obtained money from these sources under false pretenses; and

WHEREAS, At the present time societies representing organized medicine have no authority to punish such offenders; therefore be it

RESOLVED, That the Pennsylvania Medical Society go on record as being strongly opposed to allowing questionable unethical and dishonest practices to go unjudged and unpunished; and be it further

RESOLVED, That the Pennsylvania Medical Society seek legislative assistance that will allow duly appointed official Peer Review Committees to sit in judgment and recommend to the duly constituted authorities appropriate chastisement up to and including revocation of the offender's licence to practice medicine for stated periods of time.

Supplemental Report E of the Board of Trustees—Proposed Bennett Amendment to HR-17550 (Appendix B)

Your Reference Committee concurs with the action taken by the Board of Trustees approving the concept of peer review as set forth in the Bennett Amendment. In view of the fact the intent of Resolution 70-9 is embodied in the proposed Bennett Amendment, your Reference Committee recommends that Resolution 70-9 be filed for information.

Mr. Speaker, your Reference Committee recommends approval of that portion of Supplemental Report E of the Board of Trustees dealing with the Bennett Amendment.

RESOLUTION 70-4: Fee for Service (Official Reports Book—Page 148)

WHEREAS, Malpractice suits are increasing in number and frequency in Pennsylvania; and

WHEREAS, This increase is affecting the practice of medicine in our Commonwealth; and

WHEREAS, The "contingency-fee" basis used by lawyers in instituting these suits is a large factor in the number and nature of the suits instituted; therefore be it

RESOLVED, That the Pennsylvania Medical Society go on record as urging all professions that the ethical and most fair method of payment for professional services is the "fee-for-service" concept; and be it further

RESOLVED, That the intent and contents of this resolution be sent to and discussed with the Pennsylvania Bar Association by the appropriate committee of the Pennsylvania Medical Society.

Your Reference Committee learned that the intent of this Resolution has, in effect, been implemented as a result of the activities of the Society's Commission on Forensic Medicine during the past year.

Mr. Speaker, your Reference Committee recommends that Resolution 70-4 be referred to the Commission on Forensic Medicine for information.

RESOLUTION 70-5: Increased State Aid to Community Hospitals for Care of Medically Indigent (Official Reports Book—Page 148)

WHEREAS, The non-profit community hospitals in Pennsylvania are finding it financially impossible to render continual care to medically indigent patients on a \$.50 per dollar basis; and

WHEREAS, A continuation of this type of unrealistic financing on the part of our Commonwealth of Pennsylvania places a severe financial hardship on our community hospitals; and

WHEREAS, If such a hardship is not remedied soon, the community hospitals will have no alternative but to increase their rates for all paying patients; therefore be it

RESOLVED, That the Pennsylvania Medical Society request a meeting with the Hospital Association of Pennsylvania in order to solicit its cooperation in seeking adequate compensation for Pennsylvania hospitals in relation to the care of the medically indigent; and be it further

RESOLVED, That both organizations request a meeting with the Governor of Pennsylvania at the earliest possible time in order to present to him the seriousness of the situation and seek his assistance in alleviating the problem as soon as possible for the benefit of not only the medically indigent patient but the hospitals who provide such care as well.

Little or no support for this Resolution was presented to

your Reference Committee. Furthermore, the intent of this Resolution is inconsistent with the Reference Committee's recommendation under the previous section of this report regarding the Department of Public Welfare.

Mr. Speaker, your Reference Committee recommends that Resolution 70-5 be rejected.

RESOLUTION 70-17: Recognition of Physicians' Charitable Services.

WHEREAS, The amounts of payments to physicians under the Medical Assistance Program have been released by the Commonwealth's Department of Public Welfare to the news media; and

WHEREAS, Publication of such information infers wrongdoing by physicians in the view of the public; and

WHEREAS, Physicians who have greatly contributed to the Medical Assistance Program have, therefore, been exposed to unwarranted suspicion and criticism in their communities; therefore be it

RESOLVED, That the Pennsylvania Medical Society urge, in order to avoid further unjust public criticism, that the necessary steps be taken by the appropriate governmental bodies to clearly demonstrate the charitable nature of physicians' services to Medical Assistance recipients under the current program.

Testimony received by the Reference Committee reflected a complete awareness of the problem outlined in the Resolution.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 70-17.

RESOLUTION 70-18: Improved Method of Payment to Physicians Under the Commonwealth's Medical Assistance (Pennsycare) Program

WHEREAS, Physicians who treat indigent patients generally receive no payment or substantially reduced payments under the Commonwealth's Medical Assistance Program; and

WHEREAS, Physicians are not attracted to rural and urban areas which have a high concentration of indigent citizens due partially to anticipated income barely adequate to meet overhead costs which has resulted in a disproportionate ratio of physicians to serve the indigent population of our Commonwealth; and

WHEREAS, It should be recognized there are differences and problems for physicians who derive a significant portion of their income from serving indigent patients, as compared to other physicians who serve only a few of such patients and who are, therefore, better able to absorb the charity care they provide; and

WHEREAS, Despite the fact that it is the position of the Pennsylvania Medical Society that physicians should be reimbursed on a usual, customary, and reasonable fee basis, the Commonwealth's Legislature has not appropriated funds to meet this objective under the Medical Assistant Program; and

WHEREAS, It appears that physicians treating indigent patients must continue, at least in the near future, to underwrite part of the cost of the medical services for the Commonwealth's needy citizens by providing charitable services or accepting payments, under the Medical Assistance Program, at a rate of approximately 50 per cent or less of usual charges; and

WHEREAS, Physicians who treat medical assistance re-

cipients have an additional burden of overhead expenses due to payment procedure, billing, and bookkeeping requirements under the Medical Assistance Program; and

WHEREAS, If we are to meet the Pennsylvania Medical Society's objective of providing high quality medical care for all citizens, present payment methods should be improved so that indigent citizens have better access to presently scarce medical services; therefore be it

RESOLVED, That the Pennsylvania Medical Society reiterate to the Pennsylvania Department of Public Welfare that it is the society's position that physicians should be reimbursed on a usual, customary, and reasonable fee basis for services provided including those patients enrolled under the Medical Assistance Program; and be it further

RESOLVED, That the Pennsylvania Medical Society urge the Pennsylvania Department of Public Welfare to develop the Medical Assistance Program on an underwriting basis to provide Medical Assistance recipients with insurance contracts to remove the "Medical Assistance Stigma" and to improve the present inefficient, inadequate claim processing procedure which is costly to physicians and to our citizens in general; and be it further

RESOLVED, That, in order to encourage the delivery of quality medical care in the appropriate setting, the Pennsylvania Medical Society should request the Pennsylvania Department of Public Welfare to expand out-patient benefits so that physicians can be reimbursed regardless of where the service is provided; and be it further

RESOLVED, That in recognizing that funds are not presently available to increase payments to all physicians on a usual, customary, and reasonable basis, that in order to attract more physicians to practice in poverty areas, the Pennsylvania Medical Society adopt an interim policy urging the Pennsylvania Department of Public Welfare to develop a differential payment procedure which would have the effect of increasing the present level of reimbursement, on a sliding scale basis, to those physicians who treat a disproportionately high percentage of indigent patients; and be it further

RESOLVED, That the Pennsylvania Medical Society offer the guidance of the society's Council on Medical Service to the Pennsylvania Department of Public Welfare in the implementation of these recommendations.

Your Reference Committee noted that the first three "RESOLVEDS" are already Society policy. Your Reference Committee believes that the fourth "RESOLVED" is inconsistent with Society policy and appears to be an impractical approach. However, your Reference Committee is sympathetic to the problems confronting physicians practicing in poverty areas.

Mr. Speaker, your Reference Committee recommends that the Council on Medical Service be directed to explore the feasibility of incentive programs to induce physicians to practice in poverty areas.

Mr. Speaker, your Reference Committee recommends that Resolution 70-18 be not approved.

RESOLUTION 70-20: Medical Assistance Program - Commonwealth of Pennsylvania

WHEREAS, The Grants to States for Medical Assistance Programs, Title XIX, July 30, 1965, Public Law 89-97, 42 U.S.C.A. s 1396 (1966), has the announced objective of liberalizing the federal law under which states are operating medical assistance programs, making medical services of high quality more generally available for the needy, and ex-

panding a state's medical services program to persons who have income adequate for their basic maintenance but not adequate for high quality medical care. We share the concern of Congress that medical care of high quality be afforded all our citizens.

To assure that medical care provided eligible recipients will be of high quality and in no way inferior to that enjoyed by the rest of the public, Congress has made very clear its intent that realistic fees are to be paid by the states so that the voluntary participation of physicians, as well as other providers of services, will be enlisted. The insight of Congress in recognizing that usual and customary fees are to be paid and that a welfare program is not to be subsidized by requiring a physician to provide services without reasonable compensation, is exemplary.

We are aware that present budgetary considerations may not permit the Commonwealth at this time to pay a usual and customary fee for the physician's service. Regrettably, however, the Commonwealth has not shown that it has any intention at any time of establishing and paying a usual and customary fee. We are concerned that the Commonwealth's present practice of paying an inadequate fee will become an unalterable way of life.

We believe a physician's qualifications and responsibilities are individual. Honor and self-respect demand that the physician not permit his ability, learning and skill to become objects of indifference. The wish of the Commonwealth to gain for its needy citizens medical care of high quality is noble. In America, however, it is particularly essential that in the process, the Commonwealth not demand, much less expect, to be made the guardian of the physician's conscience and the judge of his just worth. The fixed and substandard fees now mandated by the Commonwealth reduce the physician's professional esteem and worth to a sullied purchase in the common market place. The Commonwealth's conduct does not merit our approval. We do not forget that we are a profession dedicated to the service of man and not a trade engaged in mere moneymaking; but we believe that the physician will find his honor in a reputation for able service to all his patients and will find his self-respect in a reputation for the deserved right to fair compensation.

We are also concerned by the fact that the Commonwealth of Pennsylvania Medical Assistance Program has elected to pay its recipients for chiropractic services. The same legislators who are proposing periodic relicensure of physicians and more stringent peer review of physicians have agreed to reimburse chiropractors for their, "adjustments", at the same rate which physicians are reimbursed for medical treatment. To place physicians' services in the same category as chiropractors, "adjustments", is unfair to the honor, dignity, and self-respect which the medical profession has earned for itself in the Commonwealth of Pennsylvania.

We are honest men and conscientious citizens. We will not be swayed by clamor or emotional appeals from the state. We are not afraid of unjust criticism, and we understand the consequences of the actions we now undertake.

NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE PENNSYLVANIA MEDICAL SOCIETY:

1. We shall continue to provide medical service of high quality in the Commonwealth of Pennsylvania. We shall make every effort to advance the integrity and dignity of the profession.

2. Consistent with the dictates of our conscience and the sense of our responsible service to the public interest, we will render service to all patients regardless of their race, religion, creed, political affiliation or ability to pay. We will exert our best efforts in our patients' behalf and shall unselfishly devote our utmost ability, learning and skill to the treatment of our patients. The care of our needy patients will in no way be inferior to the care provided the rest of our patients.

3. In determining our customary and usual fees, we will avoid fees which overestimate our ability, learning and skill, but we will also avoid fees which undervalue our ability, learning and skill. We will not subscribe to, nor permit ourselves to be controlled by, a schedule of substandard fees mandated by the Commonwealth.

4. If on or before December 31, 1970 the Commonwealth is paying what we have determined at the time of billing to be the customary and usual fee, we will subscribe to all reasonable administrative procedures suggested by the Commonwealth in effecting its Medical Assistance Program.

If, however, by December 31, 1970, the Commonwealth is not paying what we have determined at the time of billing to be the customary and usual fee, we will withdraw as participants in the Commonwealth's Medical Assistance Program. We will discontinue sending statements to the Commonwealth, and we will refuse payments from the Commonwealth tendered in behalf of needy patients. We choose not to participate in a state welfare program which is subsidized at the expense of the physician.

5. Furthermore, if by December 31, 1970 the Commonwealth of Pennsylvania has not discontinued its practice of paying recipients for chiropractic services, this shall be considered sufficient grounds for nonparticipation in the Medical Assistance Program. It is imperative that the conditions described in both paragraphs 4 and 5 be met by December 31, 1970 in order for us to continue participation in the Commonwealth of Pennsylvania's Medical Assistance Program.

6. In the event we withdraw as participants in the Commonwealth's Medical Assistance Program, we pledge to remain bound to the principles declared in paragraphs 2 and 3. We fully recognize that in the absence of any payment from the Commonwealth, the poverty of a patient may require accepting no payment from the patient or a payment less than the customary and usual fee; but we consider the principles involved to be more worthy than the monetary loss.

Your Reference Committee received extensive testimony documenting the total inadequacy of the present Medical Assistance Program. However, the Reference Committee felt the provision setting a deadline for nonparticipation in the Medical Assistance Program is unrealistic and impractical.

Therefore, your Reference Committee recommends rejection of Resolution 70-20.

RESOLUTION 70-21: Medicare, Part C

WHEREAS, The freely acknowledged intent of the Federal Administration in its Medicare Part C is to drive medicare recipients away from all forms of practice except prepaid groups through the mechanism of exclusion of insurance benefits for traditional practice patterns (solo, group, fee for service); and

WHEREAS, The Health Maintenance Organization of

the HEW is to be the vehicle for this discriminatory reshaping of the medical care system; and

WHEREAS, The laudable goal of the Federal Administration to curtail medical costs could best be accomplished through a federally stimulated redesigning of commercial health insurance policies (including Blue Cross and Blue Shield) to emphasize out of hospital care, and this without the destruction of freedom of patient or physician or insurance industry; therefore, be it

RESOLVED, That the Pennsylvania Society of Internal Medicine favors preventive medicine and health maintenance services; however, the Pennsylvania Society of Internal Medicine is strongly opposed to federal legislation which would deny to U.S. citizens, through the discriminatory use of federal monies, the freedom to select the medical care delivery service of their choice; and be it further

RESOLVED, That a copy of this resolution be submitted to the Pennsylvania Medical Society, American Society of Internal Medicine and American Medical Association with the request that there be a concerted effort on the part of these organizations to block this type of legislation at the national level whenever presented.

From testimony presented, it was the feeling of the Reference Committee that the Resolution was developed without complete understanding of the provisions of the legislation. Furthermore, the intent of the Resolution is inconsistent with the Society's position that experiments with multiple systems of health care delivery be carried out to test their utility.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 70-21.

Mr. Speaker, I move the adoption of the Report of the Reference Committee on Medical Service as a whole as amended.

Report of the Reference Committee on Governmental Relations

Ralph C. Wilde, M.D., Chairman, presented the report of the committee, which was adopted by the House.

Report of the Council on Governmental Relations (Official Reports Book—Pages 86-89)

Mr. Speaker, the Reference Committee has reviewed the report of the Council on Governmental Relations, which reports on the charges made to it by the 1969 Session of the House of Delegates. The Council reports on actions it has taken on Resolutions referred to it concerning "Reporting of Conditions Leading to Safety Hazards which, you will recall, suggested that the Society seek legislation which would permit physicians to report conditions, which, in their opinion, would adversely affect the patient's normal occupational function. The Council, being acutely aware of the present malpractice climate in Pennsylvania, very wisely sought legal counsel's advice prior to drafting legislation. Legal counsel comments to the Council in their report, and we feel that it is of sufficient interest to recount here:

"A physician who reports a patient's condition leading to safety hazards, to an appropriate party without the patient's authorization, should not be legally liable to the patient. An action for libel or slander requires malice as an essential element. The physician would have a just cause for reporting. Furthermore, the report should be truthful, and truth is a valid defense in defamation cases. An action for 'invasion of privacy' must be based upon the unreasonable or unjustifiable interference with another's interest in not having his affairs known to others. The current law, in our opinion,

permits a physician to report conditions leading to safety hazards. Legislative action would not necessarily improve or clarify the present status; on the contrary, legislative activity might result in compulsory reporting which would create more risks, burdens and uncertainties for physicians."

The Reference Committee feels that the information from legal counsel should be distributed widely to industrial physicians, and, further, industry should be encouraged to ask physicians serving them to report on such hazards.

We therefore recommend that this portion of the Council's report and the advice from legal counsel be filed for the information of the House.

The Council Report also comments on other Resolutions relating to air pollution and calls attention to the fact that public awareness is increasing and that more legislative relief is being accomplished. The Council also reports on the Resolution which was passed by the 1969 House entitled "A Separate Department of Mental Health/Mental Retardation." Your Reference Committee has learned that, since the Report of the Council on Governmental Relations was filed and printed, the State Society has testified before both the Legislature and a task force of Governor Shafer's headed by the Honorable Max Rosenn, former Secretary of Public Welfare, to the points made by Resolution 69-34. Your Reference Committee understands that very little progress will probably be forthcoming in the remaining days of the current Legislature, but has received assurances that when the 1971 session of the General Assembly reconvenes, the 1969 position will be carried forward.

The Council on Governmental Relations and its Commission on Forensic Medicine report on meetings with the Pennsylvania Bar Association's Medical/Legal Committee on the general area of malpractice and pre-litigation devices, as well as contingency fees for attorneys. It is obvious to your Reference Committee that the Commission is frustrated in its efforts at the meetings held thus far, but assures us that it will continue to work with the Bar and others in an attempt to reach some satisfactory remedies.

The Reference Committee heard testimony to the effect that the Medical Society should seriously consider a program of "countersuit" where justified, and that quite possibly a defense fund for these countersuits be established. Accordingly, your Reference Committee recommends that this information be transmitted to the Commission on Forensic Medicine for its consideration.

The Commission also reports its continuing efforts towards the creation of a Medical Examiner System. Most recently the Commission has worked with the Local Government Commission of the Pennsylvania Legislature in the design of legislation which will be introduced shortly to permit counties optional forms of government as a result of the recent Constitutional Convention.

Your Reference Committee congratulates the Commission on its persistence, and encourages it to pursue the areas of malpractice relief and the support of a Medical Examiner System, hopefully for all of Pennsylvania, but, if not, for those counties who wish it.

Your Reference Committee therefore recommends that the Report of the Commission on Forensic Medicine be filed for information.

Supplemental Report of the Council on Governmental Relations (Appendix G)

Mr. Speaker, the Reference Committee has gone over, in considerable detail, the Supplemental Report of the Council which is devoted exclusively to legislation with which the

Society has been involved through the two years of the current session of the Pennsylvania Legislature—1969 and 1970. The Legislature will automatically, because of Constitutional provisions, end on November 30, and all measures not acted upon by that time will be dead.

The Supplemental Report of the Council is literally a brief report of a great amount of work done by an obviously dedicated group. This House should be extremely pleased with the amount of legislation enacted which Medicine has supported, including the "Uniform Anatomical Gift-Act," the "Professional Corporation Act," the "Renal Dialysis Act" and others. We strongly urge every member of this House to report this information to his county medical society.

The Supplemental Report also comments on legislation which has been opposed by Medicine, and high on this list is the measure currently before the General Assembly, S-254, which would require Blue Shield to pay for chiropractic services. It is probably unnecessary for us to call this House's attention to the amount of activity that has gone on by individual members during the past two years against the bill, but it seems especially critical to your Committee, since the bill will not be acted upon finally until the Legislature returns after the November 3 Elections, that we urge a renewed effort on the part of all county medical societies to their legislators for the defeat of this bill. Because of the lateness of the hour and the importance of the legislation, your Reference Committee recommends that the House of Delegates approve a mailing to every member of the Society setting forth the provisions of the bill, and urging that he or she make it his personal business to communicate with his own legislator urging him to reject S-254 on his return to Harrisburg in November.

The Committee also received requests that county medical societies receive the voting records on medical issues of their respective representatives.

Accordingly, we recommend that this be approved and forwarded to the Council on Governmental Relations.
Recommendations No. 1 and No. 2 from the Committee on General Practice (Official Reports Book—Page 85)

The Report of the Special Committee on General Practice recommends that the Pennsylvania Medical Society support legislation before Congress designed to provide financial assistance to medical schools with established family health departments and family health training programs. Your Reference Committee has been informed that the Society already has, through Senator Scott, urged the support of such a proposal.

We are further informed that communications will be made to members of the House of Representatives since the measure is currently before that body.

Your Reference Committee recommends that the Council on Governmental Relations continue to take an active interest in this program.

The second recommendation made by the Special Committee on General Practice concerns a recommendation that the Society request the state Legislature to mandate and finance departments of family medicine in all state-supported schools. The Reference Committee is not enthusiastic about the word "mandate" and would recommend that in our communications with the Legislature we do not suggest mandate.

Your Reference Committee recommends that the report be referred to the Council for appropriate action as amended.

Address of the President-Elect—Recommendation C1 and C2—Appendix D

Your Reference Committee read with a great deal of interest President-Elect Limberger's remarks concerning the support of existing medical schools, and, further, that "the financing of new medical schools could be through a bond issue by the State."

Your Reference Committee reacts quite favorably to the need for additional medical schools and understands that the Society is embarking on this as a continuing part of its legislative program. The Reference Committee is not enthusiastic about suggesting a bond issue at this time since there seems to be an adequate number of schools if they are utilized properly, and if the students graduating from these schools will remain in Pennsylvania. Accordingly, your Reference Committee feels that the portion concerning financing for new medical schools be rejected at this time.

Address of the President—Recommendations A, C, and E—Appendix C

Your Reference Committee recommends approval of the American Medical Association's "Medicredit" measure currently before the Congress of the United States.

The president has recommended support for revision of the Medical Practice Act, and, in addition, support for the training and certification of allied health care groups.

Your Reference Committee understands that presently a special committee of the State Society is meeting with the chairman and a Special Committee of the State Board of Medical Education and Licensure for this purpose. This same group is also considering allied health personnel, and, accordingly, the Reference Committee recommends that this information be filed for their information.

President Barrett also recommended support for the concept of a single medical examining board in Pennsylvania, and, after a careful reading of the recommendation, we are of the opinion that this envisions the examination of and licensure of osteopathic physicians. It seems premature to your Committee to begin any strenuous campaign at this time, but we will suggest that this recommendation be filed for the information of the Committee to Study Relations Between Medicine and Osteopathy.

RESOLUTION 70-19: Termination of Chiropractic Licensure in Pennsylvania

WHEREAS, Chiropractic is not based on any supportive scientific evidence; and

WHEREAS, Chiropractic schools are not approved by any recognized educational accrediting agencies; and

WHEREAS, The Federal Health Manpower Commission Report of 1967 clearly labels chiropractic as cultism; and

WHEREAS, Chiropractic treatment frequently delays proper and effective medical care until it is too late and, indeed, often produces actual physical damage to patients; and

WHEREAS, Licensure standards can not redeem the scientific invalidity of chiropractic; and

WHEREAS, Mandatory medical licensure laws in Pennsylvania significantly contributed to the elimination of cultism, quackery and inferior medical education with the paradoxical exception chiropractic; therefore be it

RESOLVED, That the Pennsylvania Medical Society affirms to the Legislature of the Commonwealth of Pennsylvania and to the voters of the Commonwealth, that continued licensure of chiropractors is against the public interest and opposed to all principles of good public health; and be it further

RESOLVED, That the Pennsylvania Medical Society take prompt and continued action to convince the members of the Legislature of the Commonwealth of Pennsylvania to pass such legislation as will effectively discontinue further licensure of all practitioners of chiropractic.

Your Reference Committee reviewed with a great deal of interest the entire chiropractic problem as it relates not only to this Resolution but to Senate Bill 254, and has discovered the Council on Governmental Relations already has drafted legislation designed to prohibit the further licensing of chiropractors in the Commonwealth following its passage. The bill would prevent any of the "healing arts" licensing boards from examining or licensing anybody who has not been graduated from an accredited institution—an institution accredited by either the Joint Commission on Accreditation of Hospitals or the Office of Education of the Department of Health, Education and Welfare. None of the chiropractic institutions is so accredited.

In addition, your Committee learned that the Council will introduce a measure designed to eliminate the current brand of advertising prepared and sponsored by chiropractors.

Accordingly, your Reference Committee believes that no action is required, only that Resolution No. 70-19 be filed for the information of the Council on Governmental Relations.

RESOLUTION NO. 70-22: Drug Abuse (First Resolve)—(See Report of Reference Committee on Public Service)

Since only the first Resolve of Resolution No. 70-22 was referred to our Reference Committee, we are not inclined to make a recommendation concerning action by this House. We can say, however, that the intent of the Resolution is worthwhile, but that we find that most every Council of the State Society is in some way, shape or form, involved with the problem. Specifically, the Council on Governmental Relations has been active on the legislative front in this regard.

Accordingly, we recommend that this Resolution be filed.

Supplemental Report C of the Board of Trustees and Councilors (Official Reports Book—Page 123)

The item that occupied the most time of the Committee was Supplemental Report C of the Board of Trustees, which recommends that this House of Delegates support House Bill 2393 which would, in effect, make an abortion performed by a physician in Pennsylvania a legal procedure. There are no other stipulations.

The testimony on this report, as you might well expect, was heated on both sides of the argument. Those supporting it cited the incongruity of the present law and the allegations that abortions are being performed in Pennsylvania now. The matter of a "woman's right" to an abortion was discussed at length and the Court cases pending in Pennsylvania and the United States were talked about.

Those opposing House Bill 2393 cited their abhorrence of "abortion on demand" which they felt the bill would create. They continually pointed to the fact that there are no safeguards in the bill and that persons "acting directly under the professional supervision of such physicians" would be permitted and needs clarification.

We feel that both groups agreed that the present law was vague and difficult of interpretation. Under these circumstances it is quite clear to your Committee that a compromise is vitally necessary.

Accordingly, we recommend that Supplemental Report C be modified to suggest that House Bill 2393 be amended by the Legislature and that abortions be legal under the following circumstances:

1. There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;
2. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or
3. There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;
4. Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and
5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

The recommendation of the reference committee regarding Supplemental Report C of the Board was adopted by the House.

RESOLUTION NO. 70-10: (Amended) Performance of Abortions in the State of Pennsylvania

WHEREAS, There are a large number of criminal abortions in the State of Pennsylvania each year; and

WHEREAS, There are many women who lose their lives each year because of criminal abortions; and

WHEREAS, A woman should have the right to decide whether or not she wants to have a baby; therefore be it

RESOLVED, That the Pennsylvania Medical Society support a resolution that would authorize the following:

- A. That an abortion may be performed in the State of Pennsylvania when the following criteria are met:
- (1) Such procedures be performed by any physician who has an unrestricted license to practice medicine and surgery in the State of Pennsylvania.
 - (2) Such procedure be performed in a hospital accredited by the Joint Commission on Hospital Accreditation.
 - (3) Such procedure be performed on any female on the recommendation of a physician licensed to practice medicine and surgery in the State of Pennsylvania.
 - (4) Such procedure be performed before the beginning of the 17th week of pregnancy.

Your Reference Committee recommends that Resolution No. 70-10 be rejected.

Annual Assessment

David S. Masland, M.D., Chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report, which was adopted by the House, thereby establishing the annual assessment for 1971 at \$75.

"Mr. Speaker, Members of the House of Delegates, the Finance Committee recommends that the 1971 Annual Assessment for active members of the Pennsylvania Medical Society be \$75.

"Contingent upon the approval by the House of the 1971 Assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 10.667 per cent of the Annual Assessment be allocated to the Educational Fund of the Educational and

Scientific Trust of the Pennsylvania Medical Society, which, in the case of full-dues paying members will amount to \$8.00.

"The Finance Committee also plans to recommend to the Board of Trustees that of the Annual Assessment paid by each active member, 1.33 per cent, or in the case of full-dues paying members \$1.00, be allocated to the Medical Benevolence Fund.

"This means that rather than \$75, a total of \$66 of the Annual Assessment of each full-dues paying member will be available to the General Fund for the operating expenses of the Society."

New Business

A telegram received from Christ Presbyterian Church, Camp Hill, regarding abortion legislation, was received as

new business and referred to the Council on Governmental Relations for information. (Appendix H)

The House Recognizes the Speaker and Vice-Speaker

John L. Kelly, M.D., Delaware County moved and it was seconded that the House give a rising vote of thanks to the Speaker and Vice-Speaker for the manner in which they conducted the meeting. The delegates signified their approval by standing.

The meeting adjourned at 4:10 p.m.

Respectfully submitted,
William Y. Rial, M.D., Speaker
John B. Lovette, M.D., Vice-Speaker
Raymond C. Grandon, M.D., Secretary
Robert L. Lamb, Assistant Secretary

APPENDICES

APPENDIX A: Report of the President of the Woman's Auxiliary to the Pennsylvania Medical Society, Mrs. John A. Schneider

Dr. Barrett, Dr. Rial, officers, members, and guests of the Pennsylvania Medical Society's House of Delegates:

It is a privilege to present to you the report of your Auxiliary, which is the compilation of the combined efforts of 5,743 members in 57 organized auxiliaries in Pennsylvania. Membership-wise, we are third in the nation; California and Texas being first and second.

Financially, three important funds have received our contributions. To AMA-ERF, we have given \$9,401.24—an increase over last year of \$1,400.00. To our own Educational and Scientific Trust, 34 county auxiliaries contributed \$3,684.00. Three auxiliaries contributed \$6,716.00 through their own funds. These amounts given were in 1969, and the first six months of 1970 showed a total of \$4,042.18. To the Medical Benevolence Fund, contributions amounted to \$7,625.43, providing financial assistance to 48 persons through 24 monthly grants. These grants included 3 physicians and the balance were widows and children. How do we raise these monies? By having benefits, making and selling articles, budgeting a portion of our dues, and by giving memorials and honorariums.

We believe in "keeping our house in order" so we recommended that all county auxiliaries review their bylaws. Twelve counties have amended their bylaws and six are in the process of making revisions. The State Auxiliary Bylaws will be printed and distributed to the counties at the regional workshops in late October, 1970.

In developing our programs for the year, we usually choose the projects suggested by the Auxiliary to the American Medical Association, however, we are not bound to do so. The presidents and presidents-elect of all state medical auxiliaries submit lists of priority projects at the national conference held in Chicago in October. From these lists, five projects are chosen for that year. All projects of the auxiliary are important, thus they are covered at the National Officers' Conference. Shortly thereafter, regional workshops are held in the four regions of the United States and the priority projects are given full concentration.

Our Publications Committee compiled two issues of *Key-stone News*, the official Auxiliary newsletter, and in the interim, mailed two "Noteworthy Communiques." Our motto has been "Publish or Perish." The President taped a presentation for the radio program, "Today's Health," for the Council on Public Service of the State Society. Our publicity has been excellent throughout all of the news media.

An accurate record has been kept of our deceased members. We lost forty-four members through death and all but two were active members.

Mid-Year Conference in April, 1970, was outstanding. This was the first year that we opened one complete session to the public. We invited one adult and two students from fifty nearby high schools to attend a "Drug Abuse" program. Dr. Ellsworth R. Browneller, Secretary of Health, Commonwealth of Pennsylvania, was the main speaker. The film, "Marijuana," was shown and two drug addicts from Gaudenzia House in Philadelphia, a drug rehabilitation center, spoke. A question and answer period followed and the time was too short.

The Convention Committee has been working diligently since December, 1969, and Convention is now in "full swing."

Service groups have been active and enthusiastic. A new committee, Children and Youth, was formed because of crime, violence, sex, pornography, and drug abuse concerns. Hearing and visual screening of pre-school children and the Head Start programs were just a few of the projects adopted by the county auxiliaries. Our Chairman of this Committee is serving on the Health Task Force of the Governor's Council for Human Services.

Immunization, diabetes week, anti-smoking, alcoholism, TB testing, and blood donor days were just a few of the community health services provided. One small county auxiliary donated a little red wagon to its local hospital to transport children to and from x-ray and other departments.

Health Careers has been a priority project. There are 144 Future Nurses Clubs, 29 Health Careers Clubs, and 24 Future Physicians Clubs recorded. Thirty-three counties offered 68 scholarship grants totaling \$21,034.00. Fourteen counties offered 38 loans totaling \$12,898.00. The film, "Horizons Unlimited," was shown extensively.

We have been deeply aware of the need for Home-centered Health Care programs. They are being established in more and more communities each year. Nineteen counties reported the existence of either a homemaker, meals, or friendly visitor service. These will grow because of the intense need for them.

Our foreign friends are remembered through our international health activities. Thousands of pounds of sample pharmaceuticals and surgical supplies were sent to missions, Biafran Relief and Peace Corps. Antibiotics and supplies were sent to Chimbote, Peru. Sixteen pounds of Physicians' Desk References were contributed, glasses sent to "Eyes for the Needy," and money to Project Hope. A Korean girl,

who is an honor student at the Sook Myoung Women's University, has received tapes for a recorder, which had been given to her last year by one of our county auxiliaries. She is not blind, but teaches the blind, having received her training at the Western Pennsylvania School for the Blind in Pittsburgh. Also, money has been sent to her for food and food packages. Our doctors' wives correspond with foreign wives of doctors. Handbooks have been made for those in our country listing stores selling international foods, location of churches, important telephone numbers, and local doctors and their wives who may assist them when in need.

Letters have flown freely and vigorously to our state legislators on behalf of the Uniform Anatomical Act, Minor's Consent, and against the Chiropractors' Bill. Several county auxiliaries had a "Day in Washington" arranged by Senator Hugh Scott. Knowing the value of our PaMPAC organization, we formed a division known as "PaMPAC Membership for Women" and have urged members to join. In five counties, auxiliary legislative chairmen met with their respective medical society legislative chairmen. This, we feel, should be encouraged because it stimulates interest in legislation.

Need for a Mental Health Committee has grown like "Topsy" because of drug abuse, alcoholism, sex, mental health, and mental retardation. Every county had at least one program on "Drug Abuse." Members are serving on Mental Health boards, aid in Mental Health centers, and volunteer either in, or for, Mental institutions.

Safety was emphasized in the home, on vacation, and this year, particularly on the highways. Fifty-six thousand were killed on the U.S. highways and 41,000 Americans were killed in ten years in Vietnam. Members were encouraged to take and to teach the Defensive Driving Courses. One of our members was the first woman to be trained in defensive driving as an instructor and the first woman in Pennsylvania to teach the course. She taught 100 persons. Legislative measures were taken by writing on behalf of the "Safety Legislative Package" - the XIV Bills dealing with Traffic and Highway Safety. We still teach the GEMS course and further the block mother programs.

The auxiliary had representation on the Pennsylvania Health Council, Inc.; Community Services of Pennsylvania; and the Pennsylvania Society for Advancing Medical Research, Inc. We have a liaison to the Woman's Auxiliary to the Student American Medical Association. There are seventy chapters in the United States and we have ten in our State—six WA/SAMA chapters and four Interns' and Residents' Wives groups. These active young ladies are our future members and have chosen the theme, "Explo 70's," this year—exploring the health opportunities in the exploding health industry.

Pennsylvania is very fortunate in having a very alive and active medical society and auxiliary, both working hand-in-hand for the good of medicine and public health. The Medical Society provides an Advisory Committee to the Auxiliary and only with its approval do we function. The Auxiliary is most fortunate in having an extremely capable Executive Secretary, who handles a vast amount of business correspondence and physical arrangements for Mid-Year Conference, Convention, Regional Workshops, and many other meetings.

Where do the dues go? What does the medical society and auxiliary do for you? One of the highlights of this year was the opportunity to take a tour through the AMA headquarters in Chicago and the medical society headquarters in Lemoyne. This entailed a visit with each staff member, an exchange of ideas, and the question, "How

can the auxiliary be more useful to its parent organization?" The new name, "Careers in Health Clubs," PaMPAC Membership for Women, and an auxiliary Health Careers Financial Aid Program through the Educational and Scientific Trust were three measures adopted this year.

We deeply appreciate the invitations to attend the meetings of the Councils on Public Service, Governmental Relations, and Education and Science, and the Officers' Conference.

A slide presentation was shown to 48 of the 57 county auxiliaries explaining the structure of the County, State, and National organizations; the image of the doctor's wife in the community; the purpose and necessity for our projects and programs; and "action" slides from the counties showing how to organize them. Honoraria to the president for these county visits were used to purchase the film, "Marijuana," which was presented to the President of the State Society at Mid-Year Conference, to be used by the Society and the auxiliary.

Regional workshops were held last year in our three regions and will be held again this year, immediately following the national workshops.

The auxiliary is "on the move" in everything but membership, which showed a decrease this year. For this we are very sorry. We are your goodwill ambassadors; can provide educational programs; raise money for our funds; encourage people to go into the health fields—and we are the only ones who know the physician's "way of life." America is the only country that has voluntary organizations!

Thank you for allowing us to be "your Auxiliary."

APPENDIX B: Supplemental Report E of the Board of Trustees

The Board of Trustees met on the evening of October 4, 1970 and took several actions which are of interest to the House and, in some instances, require the consideration of the House of Delegates:

Proposed Bennett Amendment to HR-17550 (Referred to Reference Committee on Medical Service)

The Council on Medical Service discussed with the Board of Trustees its findings with regard to the proposed Bennett Amendment to the Social Security Act which would in essence place in the hands of medical societies the responsibility for determining the quality of all aspects of medical care and hospital utilization. The Bennett Amendment clearly provides organized medicine with an opportunity to assume total responsibility for establishing the professional standards and evaluating factors effecting the most efficient and economic delivery of health services consistent with high quality care. The Amendment provides the medical profession with an opportunity to demonstrate the effectiveness of peer review. Consequently, the Board of Trustees believes this is a great opportunity for the profession to provide major leadership in determining the quality of health care in this nation. The Board of Trustees has approved the Council's recommendation that the concept of peer review, as set forth in the Bennett Amendment, be endorsed in principle and the Board of Trustees now urges the House of Delegates to approve in principle the concept of peer review as set forth in the Bennett Amendment with the understanding that the Amendment would authorize the professional standards review organization to develop appropriate standards for prospective admission review rather than require written pre-authorization for hospital admissions. In the House's consideration of this recommendation, it should be noted that the Pennsylvania Hospital Association and the American Hospital Association have come out strongly against the Bennett Amendment.

Fees for Physicians Under Medical Assistance Program (Referred to Reference Committee on Medical Service)

The Council on Medical Service also apprised the Board of Trustees of the fact that it has explored in depth several questions with the Pennsylvania Department of Public Welfare concerning the Medical Assistance Program. Among other subjects, the Council pointed out that there are many benefits under the Medical Assistance Program which receive a larger share of the Medical Assistance budget than is allocated for payment of physician services. It was also noted that on occasion payment has been increased for the services of certain providers without proportionate increases to all providers under the Medical Assistance Program. As a result, the Board of Trustees, upon the recommendation of the Council on Medical Service, determined to urge the Pennsylvania Department of Public Welfare to upgrade payments for services presently covered under the Medical Assistance Program before including additional benefits and to urge that when payments are increased to any provider under the program that a proportionate increase be extended to cover services for all providers to provide a relative equitable level of payment.

Recommendation Concerning the Composition of the Committee on Objectives (Referred to Reference Committee on Standing and Special Committees)

In its report on the projected 1971 budget, the Finance Committee, cognizant of its charge by the Board of Trustees to act as an evaluation committee, expressed its belief that consideration should be given to the possibility of reducing the size of the Committee on Objectives. Currently the committee is composed of fifteen members who serve terms of three years, five members being appointed annually by the president. It is the feeling of the Finance Committee and the Board of Trustees that a committee scaled down to a more workable size might be able to achieve its basic objectives with greater facility. The Board of Trustees commends the Committee on Objectives for its serious and conscientious approach to its responsibilities, but the Board seriously believes that the committee has been hindered in achieving its basic commission by virtue of the cumbersome size of the committee. As this matter is considered by the appropriate reference committee, the Board of Trustees urges the committee to give consideration to establishing some guidelines for the president in reducing the present committee to a more workable size, should the reference committee recommend favorable action with regard to the Board of Trustees' position. The Board's definition of a committee of workable size is a committee of five or some number in that immediate neighborhood.

Endorsement of Concept of Institute for Continuing Education (Referred to Reference Committee on Education and Science)

For some time the Council on Education and Science, through its Advisory Committee on Physician Education, has been exploring the concept of creating jointly in cooperation with other interested organizations an institute for post-graduate education which would coordinate the continuing education programs throughout Pennsylvania. The object of such an institute would be to evaluate physician needs, correlate and synchronize the various programs throughout the state, and innovate varied appropriate educational tools and mechanisms to assist in their quest for effective continuing education. As yet the Council is not ready to present either to this House of Delegates or to the Board of Trustees a detailed plan for implementing the concept. As of now, these details are still being worked out by

the Council. However, last evening through the medium of the report from the president of the Society, William A. Barrett, M.D., the Board of Trustees determined to recommend to the House of Delegates that it go on record as endorsing in principle the concept of an institute for continuing education which would be jointly sponsored and financed initially by the Pennsylvania Medical Society and other interested organizations.

Resolution for Introduction in the American Medical Association House of Delegates (Referred to Reference Committee on Education and Science)

Subject: Meeting on the Clinical Aspects of Geriatric Medicine Prior to the White House Conference on this Subject

At its last meeting the Board of Trustees reviewed a resolution submitted by the Council on Education and Science through its Commission on Geriatrics. It was suggested by the Council that the resolution be submitted by the Pennsylvania Delegation to the AMA House of Delegates for action at its meeting in November. Since the meeting of the Board of Trustees was held just prior to this meeting of the House of Delegates, the Board determined to refer the resolution for consideration by the House. The Board of Trustees did not take a position concerning whether or not the resolution should be introduced by the Pennsylvania Delegation but chose, rather, to have the appropriate reference committee consider this in detail and make its recommendation directly to the House of Delegates. The resolution follows:

RESOLUTION NO. 70-24

(Referred to Reference Committee on Education and Science)

Introduced by: Board of Trustees and Councilors

WHEREAS, Experience at two previous sessions of the White House Conference on the Aging, held ten years apart in Washington, D.C., has indicated that welfare departments have been energetic and efficient in promoting individual welfare-oriented state plans; and

WHEREAS, These White House Conferences are structured in such a fashion that clinical needs to get presented but usually in a way that tends to make primary health aspects of aging citizens subservient to sociological problems, economic considerations, nursing home requirements and the like; and

WHEREAS, A strong medical approach to public health and personal health of the elderly needs to be emphasized at this important session; and

WHEREAS, A consensus is sorely needed by which state medical society groups can adjust their relationships to governmental agencies in order to ensure medically-oriented action and to influence decisions; therefore be it

RESOLVED, That the American Medical Association or a state medical society, with the cooperation of the services of the American Medical Association, call a meeting immediately prior to the White House Conference (scheduled for November 1971) of all state medical society chairmen of geriatrics, or their counterparts, to prepare a statement on the clinical aspects on aging to be submitted as part of the record of the 1971 White House Conference.

Membership Requirement for Continuing Education (Referred to Reference Committee on Education and Science)

In its report to the House of Delegates, the Council on Education and Science discusses in some detail its conviction that minimum standards for continuing education should be established as a requirement for membership. The

Board of Trustees has deliberated this question long and hard on several occasions and not without some anguish. It recognizes the need to establish minimum criteria for continuing education among the membership, but the source of much of its hesitation about resolving the question gravitated around the actual details of the requirement program and the larger issue of whether or not the membership would accept this mandatory requirement in good conscience or whether many members would resign to avoid compliance and thereby put some of the Society's most crucial programs in jeopardy during this critical era of increased federal and state involvement in the practice of medicine. At its meeting, however, the Board of Trustees determined to endorse in principle the concept of creating minimum standards for continuing education as a requirement for membership. However, the Board of Trustees is not at this juncture prepared to endorse a particular program as the minimum requirement for education, nor is it ready to support the establishment of an effective date for such a membership requirement. It is the feeling of the Board of Trustees that both these questions require further and very careful deliberation.

Opinion Survey of Medical Students (Referred to Reference Committee on Public Service)

The Board of Trustees reviewed a recommendation by the Council on Public Service that a survey of medical students be instituted in order to assess more effectively the means through which the Medical Society can communicate with and motivate students. The Council estimates that such a survey will cost somewhere in the neighborhood of \$4,000. Currently the projected deficit for the 1971 budget is over \$18,000 and it could go higher, depending upon other programs approved by the House at this meeting. In view of the deficit position of the 1971 budget, the Board of Trustees determined to approve the concept of such a survey in principle and to convey its endorsement to the House of Delegates without actually allocating funds for such a survey at this juncture. The Board of Trustees prefers, instead, to have the House of Delegates consider this matter carefully in detail and then instruct the Board of Trustees as to whether or not in the opinion of the House such a survey should be financed and implemented in a year of projected deficit.

In addition to the actions above, the Board of Trustees considered many recommendations and took several actions which do not impact directly on the business of the House of Delegates. However, the Chairman of the Board and other key officers of the Society will be present at the Reference Committee on Reports of Officers and will be glad to review in greater detail any aspect of the Board's stewardship in the past year, including further details in connection with its latest meeting.

APPENDIX C: Referrals From the Address of Dr. Barrett (Full text appeared in the November issue of PENNSYLVANIA MEDICINE)

A. Sections entitled Health Care Manpower, Medical Education and Medical School Expansion

"I recommend that this be started by a meeting of the deans of the medical schools in Pennsylvania with knowledgeable representatives of the Pennsylvania Medical Society: (a) to discuss ways and means of increasing medical school enrollment; (b) to consider appropriate recommendations to the

Pennsylvania Legislature and the Congress; and, (c) to apprise the general public of the tax responsibility that goes with its right to medical care."

Referred to Reference Committee on Education and Science

B. Section entitled Allied Health Care Personnel

"I recommend that this Society continue to assist the various health care groups to define their educational requirements and establish training standards, and that we assist the Board of Medical Education and Licensure in revising the Medical Practice Act so that these other members of the health care team can be appropriately certified."

Referred to Reference Committee on Education and Science

C. Section entitled Medical Practice Act

"I recommend that this House of Delegates (a) support the revision of the Medical Practice Act; (b) encourage the training and certification of all allied health care groups; and (c) support the concept of a single medical examining board in Pennsylvania."

Referred to Reference Committee on Governmental Relations

D. Section entitled Continuing Medical Education

1. "I recommend that: (a) the Pennsylvania Medical Continuing Education Institute be founded, for the primary purpose of promoting the continuing education of physicians and allied health care groups; (b) the organizational structure be a separate corporation with 15 trustees who shall also be the Board of Trustees of the Pennsylvania Medical Society, and governed by a representative board of directors elected by the trustees; (c) as many as necessary of the present staff now serving the Council on Education and Science be allocated to the activities of the institute; (d) the educational programs and scientific meetings, activities and responsibilities be transferred to the institute; (e) advice of legal counsel be obtained regarding the possible and advisable options of organizing such a body; and, (f) a physician medical educator be employed, on a part-time basis at first, not only to develop and direct appropriate educational programs but also to help mold and direct the growth of the institute."

Referred to Reference Committee on Education and Science

2. "I recommend that this House support the above recommendation of the Council on Education and Science."

Referred to Reference Committee on Education and Science

E. Section entitled Legislation and PaMPAC

1. "I recommend that all county medical societies be urged to include PaMPAC membership dues as part of their regular dues statements."

Referred to Reference Committee on Reports of Officers

2. "I recommend that every county medical society build a fire under its legislative committee and insist upon (a) at least annual meetings with all legislators from that county; (b) that specific physicians be charged with a personal contact of each county

legislator, on a personal and social basis, if possible; (c) that the county Woman's Auxiliary be requested to assist in both activities; (d) that the State Society position on each proposed piece of legislation which affects medical care or the profession be sent to the individual legislator with a note over the signature of the individual physician charged with that contact."

Referred to Reference Committee on Governmental Relations

F. Section entitled Council on Medical Service

"I recommend that the Society take whatever steps are necessary, including legislative ones, to have the Department of Public Welfare provide prepaid hospital and medical insurance contracts for all of its beneficiaries."

Referred to Reference Committee on Medical Service

G. Section entitled Prepaid Insurance Programs

1. "I recommend that these and similar areas of cooperation be pursued actively by the Society by whatsoever means may be required."

Referred to Reference Committee on Medical Service

2. "I recommend that the State Society continue to develop such a Blue Shield-Blue Cross program for those counties who wish to participate."

Referred to Reference Committee on Medical Service

H. Section entitled Social Security Administration

No specific recommendation.

Referred to Reference Committee on Medical Service.

I. Section entitled Peer Review

"I recommend that the Pennsylvania Medical Society officially endorse the AMA Medcredit Bill and actively work toward its passage by the Congress."

Referred to Reference Committee on Governmental Relations

J. Section entitled Foundation for Medical Care

"I recommend that this House of Delegates; (a) approve in principle the concept of a Pennsylvania Medical Society Foundation for Medical Care; (b) direct the Board of Trustees and Council on Medical Service to proceed with a study of the possibilities and develop a specific plan for the organization and operation of a medical care foundation; and (c) direct legal counsel to study the necessary steps and requirements between the Society and the Social Security Administration and between the Society and other purveyors and insurers of medical and facility care. I further recommend that the plan or plans, opinions of legal counsel, costs and recommendations be submitted to the House of Delegates at its regular 1971 session."

Referred to Reference Committee on Medical Service

K. Section entitled Public Service

"I recommend that the reference committee and this House in considering the introductory portion of the

council's report give the council specific guidance on the direction in which you would have it turn."

Referred to Reference Committee on Public Service

L. Section entitled Structure and Services

No specific recommendations.

Referred to Reference Committee on Reports of Officers

APPENDIX D: Referrals From the Address of Dr. Limberger (Full text appeared in the November issue of PENNSYLVANIA MEDICINE)

A. Introductory Comments

Referred to Reference Committee on Reports of Officers

B. Manpower: Medical and Allied Health Personnel

1. "It is recommended that the Pennsylvania Medical Society encourage the medical schools to explore the increasing use of these two educational sources (described in comments) with the medical schools acting as the administrative centers and subcontracting courses among the colleges and hospitals at all levels of medical education."

Referred to Reference Committee on Education and Science

2. "It is recommended that the Pennsylvania Medical Society take a more active part in soliciting the support of the members of the Pennsylvania Legislature for such a plan (described in comments)."

Referred to Reference Committee on Governmental Relations

"The financing of new medical schools could be through a large bond issue by the state, and it is recommended that this program be proposed (to the state legislature) and actively supported by the State Society."

Referred to Reference Committee on Governmental Relations

C. Medical Education.

1. "It is recommended that the Pennsylvania Medical Society continue to urge medical schools to take more definitive action toward educating the primary physician."

Referred to Reference Committee on Education and Science

2. "It is recommended that the Pennsylvania Medical Society continue to urge the medical schools to produce physicians who are more relevant to societal needs of the citizens."

Referred to Reference Committee on Education and Science

D. Continuing Education.

1. "It is recommended that the Pennsylvania Medical Society, through its Council on Education and Science, urge the Pennsylvania Academy of General Practice to develop examinations for all members of the Pennsylvania Medical Society engaged in family medicine and to urge every specialty group organized in the Commonwealth to do likewise for their members."

Referred to Reference Committee on Education and Science

2. "It is recommended that the House reaffirm its approval of the direction taken by the Council and that it urge the Council to proceed with submitting a complete plan (for a Pennsylvania Medical Continuing Education Institute) to the Board of Trustees and Councilors as soon as possible."

Referred to Reference Committee on Education and Science

3. "It is recommended that the Council on Education and Science be commended for its activity in this field (physician competence), and it is urged that the House of Delegates seriously consider its recommendations in continuing education."

Referred to Reference Committee on Education and Science

E. Allied Health Personnel.

"It is recommended that the Pennsylvania Medical Society cooperate with the State Board of Medical Education and Licensure in introducing necessary legislation to cover this allied health group."

Referred to Reference Committee on Education and Science

F. Delivery of Health Care.

1. "It is recommended that the Pennsylvania Medical Society encourage and assist smaller cities and towns in the state who have economically depressed areas to become active in this field and encourage the local county medical societies to take an active part in this endeavor."

Referred to Reference Committee on Medical Service

2. "It is recommended that the Pennsylvania Medical Society offer its good services to the West Perry Clinic Corporation to help in conducting such a survey and if, at the conclusion of this study, the program is deemed feasible, to help in securing the "seed money" necessary to start the program in operation."

Referred to Reference Committee on Public Service

G. Peer Review.

"It is recommended that each county medical society establish a peer review committee and formulate plans for implementing this program in their individual county. It is also recommended that the Council on Medical Service and the Council on Education and Science jointly prepare guidelines for peer review activity at a county level and distribute them to the individual county medical societies."

Referred to Reference Committee on Medical Service

H. Communications.

Referred to Reference Committee on Public Service

I. Litigation and Insurance for Medical Liability.

"This seems worthy of further investigation (arbitration), and it is recommended that the Council on Medical Service and the Council on Governmental Relations continue to explore the feasibility of the utilization of arbitration boards as the solution to this problem."

Referred to Reference Committee on Medical Service

J. PaMPAC.

"It is recommended that the six county medical societies seriously consider including PaMPAC membership dues in their billings and that all county medical societies include AMPAC-PaMPAC dues as one item in the total amount billed."

Referred to Reference Committee on Reports of Officers

K. In Conclusion.

Referred to Reference Committee on Reports of Officers

APPENDIX E: Supplemental Report of the Council on Education and Science

At the writing of our annual report, we had not been advised of the results of the AMA survey to determine whether or not the State Society could be approved as an accredited institution for planning continuing medical education programs. Word now has been received from Dr. C. H. William Ruhe, Secretary to the Council on Medical Education of the American Medical Association, as follows:

"From the information available to the Committee on May 20th, it seemed that there had been some excellent planning by dedicated and knowledgeable people, but that the program itself as a function of the Pennsylvania Medical Society was not yet adequately implemented.

Therefore, even though the consultant team recommended accreditation, the Committee voted to recommend to the Council on Medical Education that the program of continuing medical education of the Pennsylvania Medical Society be not accredited at this time.

"The Council on Medical Education has accepted this recommendation and would like to have the Pennsylvania Medical Society apply for accreditation when the program is in full operation."

In January 1970, the Council proposed to the Board of Trustees and Councilors that minimum standards for continuing education as a requirement for membership should be instituted by the Pennsylvania Medical Society. The Council, at its 1969 fall meeting, concluded that every physician engaged in the practice of medicine in Pennsylvania should have a basic core of information and that it should be continually updated. Since voluntary motivation on the part of the individual physician has not always been successful, the Council was of the opinion that compulsory motivation could and should be initiated by the State Society as a fulfillment of its responsibility of leadership. The Council expressed the feeling that if the State Society does not initiate steps for minimum standards of continuing education, leadership will fall into other hands less aware of the problems involved. The Council stated that caution should be exercised in developing these standards because any action such as this would affect county medical society membership also.

Supporting this concept was the 1969 report of the Committee on Objectives which discussed the relicensure of physicians and urged caution. It favored a gradual approach to this problem, beginning with a more effective voluntary continuing education program. It stated that if periodic relicensure be deemed necessary, it should be based on educational credits rather than on a challenge examination. The

1969 House of Delegates had already approved the recommendation of the President requesting that each member of the Society qualify for the American Medical Association Physician's Recognition Award involving 150 hours of continuing education every 3 years. A mandatory membership requirement for Pennsylvania Medical Society members in regard to continuing education would be a positive way to implement both recommendations.

The Council, therefore, recommended, in January 1970, that the State Society should proceed to set standards for continuing education as a requirement for membership in this Society. The Board of Trustees changed the recommendation to indicate that "the Society should proceed to study minimum standards for continuing education as a requirement for membership in this Society," and referred the matter to the Council once more.

At the May 1970 meeting of the Board of Trustees, the Council reported that a number of steps had been taken to establish a more effective voluntary continuing education program and that those members of the Society in the more isolated areas of Pennsylvania were now able to take part in community hospital programs offered by the Council. The Council also was attempting to receive official recognition as an educational institution by the AMA Council on Medical Education. It was the Council's feeling that these significant steps would have a dual benefit of encouraging more voluntary participation in programs which the Council was sponsoring and also make it easier for PMS members to find courses that were approved for the AMA's Recognition Award. The Council, at that time, recommended to the Board of Trustees that "the Society should not entertain thoughts of periodic relicensure. It should, however, require all its members to have achieved the requirements of the AMA Physician's Recognition Award in order to retain membership in the Pennsylvania Medical Society, and should urge each of the component county societies to do the same." It further recommended that the effective date of this membership requirement be July 1, 1972, which would coincide with the yearly qualifying period established for the AMA Physician's Recognition Award. The Board of Trustees approved this recommendation in principle and determined to refer it favorably to the House of Delegates. As a supplemental action, the Board directed the Council to spell out specific details of such a membership requirement and report them to the Board for approval.

In August 1970, the Council reported back to the Board of Trustees with specific details for the continuing education membership requirement. In its deliberation, the Council had reviewed the AMA Physician's Recognition Award; report of the Council on Medical Education of the Oregon Medical Association, April 1970; report of the Scientific Board, California Medical Association, February 1970; actions of the Board of Regents of the American College of Physicians, January 1970 regarding an educational participation requirement. The specific details outlined by the Council were as follows:

A. Effective Date

The AMA Physician's Recognition Award allows for a three-year qualifying period. All qualifying periods begin July 1—three years prior to the granting of the certificate. In order to allow adequate notice to all members and constituent county medical societies of the Pennsylvania Medical Society, we believe that the effective date for our program—July 1, 1972—should be the beginning date of the three-year qualifying period.

B. Collecting Data

The AMA Council on Medical Education indicates that data available on their "Physician's Recognition Award" records can be summarized for use by PMS. Hence, the name of any member who has qualified for the AMA Recognition Award in any year can be reported to the PMS as meeting the continuing medical education membership requirement of PMS. Since it is possible that a few members may prefer to submit records of continuing education directly to PMS, provision for such exigencies should be made. It would be understood, of course, that such situations would be rare and final verification would still be done by the AMA Council on Medical Education.

C. Implementation

Beginning July 1, 1975 and effective each July 1 thereafter, the Executive Director will have a list prepared, indicating the name of each Active and Senior Active member who has not qualified for the AMA Physician's Recognition Award. Each such member will be notified immediately of this apparent lack in his continuing medical education. At the same time, he will be informed that no further action will be taken if, by September 1, he is able to submit sufficient supplemental records to fulfill the Physician's Recognition Award requirements.

If supplemental information has not been received by September 1, the Executive Director will notify each such member that his membership will be suspended effective December 31 for a period of one year. If supplemental reports are received before the December 31 date, of course, the suspension will not become effective.

The suspended member should not be entitled to exercise any of the rights or privileges of membership during the period of suspension, should be required to continue the payment of annual assessments, and should be restored to full membership upon the expiration of the period of suspension provided he holds a current AMA Physician's Recognition Award certificate.

Suspended members who have not completed the continuing medical education requirements by the end of the period of suspension, should have their membership terminated immediately. Any person whose membership has been terminated for failure to meet the continuing medical education requirement shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met the requirements for the AMA Physician's Recognition Award for the current period and at least one third of the hours required were obtained during the current calendar year.

D. Exceptions

It is understood that no continuing medical education requirement can be placed against a new membership until sufficient time has elapsed for that member to qualify for the AMA Physician's Recognition Award. This would apply particularly to persons whose previous membership was in a state where there is no continuing medical education requirement.

Using this as background information, the Council then recommended that all of these guidelines be referred to the Committee on Constitution and By-Laws with a request for the preparation of appropriate amendments for consideration by this 1970 House of Delegates.

The Board, in a close vote, rejected the recommendation and, in addition, rescinded its action of May which had approved the principle of requiring all active members to qualify for the AMA Physician's Recognition Award in order to retain membership in the Pennsylvania Medical Society. The rejection was based primarily on the alleged loss of membership which such a requirement would cause. It is the Council's contention that if this Society hopes to maintain the support and interest of the present members and if it is to maintain its leadership in the field of continuing medical education, the Society must demonstrate its professionalism and establish a requirement for continuing medical education as a membership standard.

This Council, therefore, recommends that this House of Delegates, as the policy-making body of this Society, not entertain thoughts of periodic relicensure but rather require all of the active members to qualify for the AMA Physician's Recognition Award in order to retain membership in the Pennsylvania Medical Society. The recommended effective date for this membership requirement would be July 1, 1972, which would coincide with the beginning of a yearly-qualifying period established for the AMA Physician's Recognition Award. It is further recommended that the Committee on Constitution and By-Laws be requested to prepare the necessary amendments to implement this and present them to this House of Delegates. Similar action on the part of each component county medical society is urged.

APPENDIX F: Report of William B. West, M.D., PaMPAC Chairman

Mr. Speaker, Mr. President, Mr. President-Elect, members of the House, distinguished guests: I appreciate this opportunity to report about the political arm of our medical Society.

Much has transpired since the Annual Session of 1969, when I last reported to you on the Pennsylvania Medical Political Action Committee. We have found that the political arena has been getting crowded with other organizations who have seen the need to have a voice in the selection and election of governmental officials. The May 19 primary this year showed some surprises, and above all, the political activity by special interest groups played an important role in the outcome of many elections.

Our Commonwealth has been experiencing a financial crisis, and the mood of the voters is "to throw the rascals out of office." Through all this turmoil, however, we must remember that the legislative machinery of the Pennsylvania Medical Society was still in motion, and we saw the passage of important pieces of legislation pertaining to health care. Such bills as the Anatomical Gift Act, Renal Dialysis, Consent for Minors to Medical Treatment and the Methadone Bill had been enacted and signed by the governor. On the national level, over 1200 bills that directly or indirectly affect the health field were introduced. Thus, the importance for supporting candidates who share medicine's viewpoints should be obvious to even the skeptic. The profound activity of all levels of government in medical practice is now common knowledge. It is matched by similar activity in medical education, in medical research, as well as in the distribution of physicians and many other activities concerned with health care. And government involvement can only increase.

During the past year our medical schools experienced a cutback in appropriations for student loans from the federal

government. There has also been a cry from medical research that there is not enough money available. In PaMPAC's efforts to promote political activity within the medical academic community, a dinner reception was held in Philadelphia in which all of the deans of the medical schools and some other physicians who serve on the hospital staffs of the medical schools were invited. The guest speaker was Congressman Daniel Flood (D), who serves as chairman of the Subcommittee on Appropriations of Labor, Health, Education and Welfare. Congressman Flood emphasized the necessity of physicians becoming involved in organized political activity since the elected officials are the ones who decide where the appropriations will be channelled. I might add that only 12.2 per cent of the physicians on the faculties of the seven Pennsylvania medical schools are members of PaMPAC. Approximately 30 per cent of the membership of the Pennsylvania Medical Society are members of PaMPAC. These figures indeed are not very encouraging. As, Dr. Carl Lechner, in an editorial of PENNSYLVANIA MEDICINE, December 1969, stated..... "If there were no PAC movement, the more than two thirds of physicians who fail to support it would certainly contain the great majority of those who would be crying in the political wilderness: 'Why cannot our Medical Society have some kind of organization to teach us how to look after our political interests?'"

The two primary objectives of PaMPAC are (1) supporting candidates and (2) political education. With the general election just less than a month away PaMPAC has been witnessing an increasing number of physicians and their wives playing vital roles on the grass roots level, giving their time and talent to the effort of helping to get their candidate elected. Regardless of party affiliation PaMPAC encourages this type of activity, and again—to emphasize a very important point—The Pennsylvania Medical Political Action Committee supports the candidate who hopefully is friendly to medicine. It does not support the Republican or Democratic Party.

In the May 19 Primary of this year, PaMPAC saw the need to support 25 candidates. Of the 25 candidates supported, 21 have won the nomination for the general election. PaMPAC's activity will surely be reflected in the general election since our state political action committee along with the other state PACs have helped make the American Medical Political Action Committee the fourth largest organized political activity in the country, exceeded only by the National Republican and Democratic Committees and COPE (Labor's Committee on Political Education).

For the second consecutive year, PaMPAC sponsored an essay contest for first year students of the seven medical schools in Pennsylvania. The purpose of this contest is to have the medical students illustrate their knowledge of medical practice within the framework of a free enterprise society. Seven medical students were awarded \$500 scholarships based upon an essay on the topic "Is There a Generation Gap in Medicine?"

PaMPAC sponsored its second statewide political action workshop in 1970. During the two-day session in Harrisburg, national and state issues and some answers for them were joined with a plea for grass roots political and civic activity. Every county medical society was invited to send two representatives and every women's auxiliary to the county medical society was invited to send one representative to the workshop. Panel discussions during the program brought political matters down to the individual level and attempted to show the need for every American to know

about the issues facing the Commonwealth and the nation, and to follow his conscience in taking action to affect changes. We also introduced a new political action slide presentation which specifically points out the activities of PaMPAC and how our state PAC coordinates with AMPAC both in dues dollars and assistance. I invite all county medical societies to take advantage of this presentation by having our staff and board members show this program at the county society's monthly meetings.

This past year of reflection and experience has definitely set the pace for our political arm in 1971. We must continue to build our membership for the elections in 1972, if we are to make our voices heard. Political activity is a continuing process and with sufficient support we can help promote better health care. I urge everyone to cast his vote on November 3.

APPENDIX G: Supplemental Report—Council On Governmental Relations (Referred to Reference Committee on Governmental Relations)

Below is a chart showing the current status of those measures in which the Pennsylvania Medical Society has had an interest during the 1969-70 session of the Pennsylvania General Assembly.

During these two years of the session, the Society has communicated with the legislators on a host of subjects, and, in addition, has presented formal testimony on many items which include: paramedical personnel, generic prescribing, a department of human services, licensure for hypnotists, chiropractic services in the Blue Shield Plan, a

new Drug, Device and Cosmetic Act, the creation of a Pennsylvania Health Agency, a Uniform Anatomical Gift Act, a Medical Examiner System, rights of mental patients, etc.

Your Council is pleased to report that most of the positive programs which it supported have become law, i.e., Professional Corporation Act, Uniform Anatomical Gift Act, the Renal Dialysis Act, Consent for Minors to Medical Treatment Act, the Methadone Act and much of the environmental control legislation encouraged by this House. In addition, legislation has been prepared by the Local Government Commission under the so-called "Optional Forms of County Government" which will permit the establishment of Medical Examiners under county government. We were also successful in having passed a resolution which will require the Legislature to study the less-than-desirable conditions under which the state licensing boards are permitted to operate.

Almost none of the legislation that we opposed has become law. Perhaps the most amount of our time has been spent fighting Senate Bill No. 254, the measure to place chiropractic services in Blue Shield. As of this writing, the bill passed the Senate, was defeated twice in House Committee and once on the House Floor. Normally, this would be enough, but the bill was approved for "reconsideration" and will be voted on again when the Legislature returns after the November elections. All county medical societies should encourage each of their members to continue to communicate with their legislators in opposition to S-254 which would place very questionable non-medical services in a medical program.

PROGRESS ON LEGISLATION OF MEDICAL INTEREST
IN THE PENNSYLVANIA GENERAL ASSEMBLY—1969-70

October 1, 1970

Bill No.	Explanation	Society's Position	Legislative History
H-2	"Uniform Anatomical Gift Act"	Support	Signed by the Governor Dec. 16, 1969; Act. No. 161
H-94	License hypnotists	Opposition in its present form	Recommitted to the Rules Committee of the House
H-136) S-448) S-449) H-675) H-1311)	Department of Health to create renal dialysis program	Support	The House approved the fiscal amendments in H-1311 placed by the Senate in June, 1970. The bill contains a \$1 million appropriation for the purpose of getting the program started. Governor signed Bill June 23, 1970; Act No. 140 of 1970
H-292	Permits discovery of insurance before trial in malpractice cases and other personal injury litigation	Opposition	Measure defeated on two occasions in the House; voted down finally 66-124
H-311) H-312) H-313) S-254)	Requires Blue Shield to include payments to chiropractors	Opposition	S-254 passed in Senate. Voted down twice in House Committee on Health and Welfare. Placed on House Calendar in June 1970; Voted down 83-102, but Bill was

Bill No.	Explanation	Society's Position	Legislative History
			reconsidered. Currently on House Calendar for action in November
H-339	Amends "Public School Code" to permit chiropractors to participate in school health programs	Opposition	Currently before the Committee on Education in the House
H-379	Would permit licensure of psychologists	No opposition since compromise language was agreed upon	Passed in House — 171-4; referred to Committee on State Government in Senate
H-459	Society-sponsored measure to clarify "informed consent" doctrine	Support	Referred to Committee on Judiciary in the House
S-780	Amends the "Medical Practice Act," providing for registration of persons engaged in the practice of drugless therapy. Requires chiropractors to take post-graduate training prior to re-licensure	No position	Recommitted to Senate Public Health and Welfare Committee on July 7, 1970
H-810	Permits employees to choose any licensed practitioner of the "healing arts" under Workmen's Compensation	Opposition	Passed House; currently in Senate Committee on Labor and Industry
H-876	Amends the "Vehicle Code" to relieve physicians from any civil or criminal liability when administering blood tests	Support	Referred to the Committee on Highway Safety of the House
H-775	Enables minors to consent to medical treatment and exempt physicians from liability	Support	Signed by the Governor Feb. 13, 1970; Act. No. 10
H-836	An Act amending the "Optometrists Licensure Law" prescribing certain courses of study as a condition to renewal of certificate for optometrists	Academy of Ophthalmology opposes this Bill	Passed in the House 168-20 on June 3, 1969; recommitted to Education in Senate. June 30, 1970
S-759	Authorizes the use of "methadone" for research or the cure or treatment of the drug habit in certain clinics designated by the Secretary	Support	Approved by the Governor Jan. 12, 1970; Act No. 186
S-1005	"Professional Corporations Act"	Support	Approved by the Governor July 9, 1970; Act. No. 160
S-1166	Amending the "Podiatry Act of 1956" changing the definition of podiatry and imposing powers and duties on the Board	No objection with the Society's amendments;	Approved by the Governor July 8, 1970; Act No. 158
H-1180	Would require registration of mentally retarded persons and state responsibilities	Pennsylvania Psychiatric Society opposes	Recommitted to the House Appropriations Committee
H-1289 H-1290	Requiring physicians to prescribe and pharmacists to fill in certain cases prescriptions by generic names	Opposition	Before Committee on Health and Welfare of the House
S-429	Would exempt physicians and nurses from liability for ordinary negligence in mass immunization projects	Support	Before the Judiciary Committee of the Senate

Bill No.	Explanation	Society's Position	Legislative History
S-507	Would relieve physicians and hospitals from liability and give consent to emergency	Support	Passed Senate; before Judiciary Committee of the House
S-788	Would require measles immunization before entrance to school	Support	Passed Senate; before House Committee on Health and Welfare
S-815 S-816 H-1141 H-1142	These bills adopt minimum standards of mental treatment and care; providing legal rights, hearings, remedies to such patients and making an appropriation	Commission on Mental Health of the Society has testified in favor of these measures	These bills remain in Committee
S-876	Would turn state-owned general hospitals back to communities	Support	Before Committee on Health and Welfare of the House
S-893	Would permit chiropractors to do drivers' physicals	Opposition	In Senate Committee on Highways
S-994	Creates Hospital Control Commission to regulate rates, construction, utilization	Opposition	In Public Health and Welfare Committee of the Senate
S-1046	Authorizes eye examinations for drivers' licensing to be done by physicians instead of by State Police	Opposition	Re-referred to Public Health and Welfare of the Senate on February 25, 1970
H-2090	Permits the appointment of a non-physician as a Director of a County Health unit	Opposition unless amended to permit option; amendments not added	Approved by Governor; Act No. 142 of 1970
H-2183	"Pennsylvania Health Agency Act"—creates independent administrative body subdivided into five control boards to control the provision and providers of all health services	Opposition	Referred to the Committee on Consumer Protection; hearings held—Society testified
H-2192	Establishes an independent Pennsylvania Drug, Narcotic and Alcohol Abuse Commission to develop and coordinate a comprehensive health, education and rehabilitation program for the prevention and treatment of drug abuse and drug dependence providing for short term civil commitment for emergency medical treatment	Under study by Commission on Mental Health	Currently on House Calendar
H-2193	Relates to the manufacture, sale and possession of drugs, devices and cosmetics; conferring powers of the courts and the Secretary and Department of Health and a newly created Pennsylvania Drug, Device and Cosmetic Board	No opposition if amendments are accepted	Society testified; our amendments added to present version; currently on House Calendar
H-Res. No. 53	Joint State Government Commission to study relation of State Licensing Board to the Administration	Support; since Medical Board receives inadequate money and clerical help	Passed House; study currently under way

Bill No.	Explanation	Society's Position	Legislative History
Reorgan-ization Plan #2	Would transfer health functions from the Department of Welfare to Department of Health	Support	Defeated in House; Senate plans to introduce its own legislation
Concurrent Res.Serial No. 204	Would authorize a Joint House/Senate Committee to investigate overlapping in Health and Public Welfare Departments	Support	Re-referred to Senate Rules Committee after being reported favorably on one occasion

APPENDIX H: Telegram from Christ Presbyterian Church, Camp Hill

Chairman, House of Delegates, Pennsylvania Medical Society, Host Farm Motel, Lancaster
 We are concerned Christians—Support your efforts to make legal abortion equally available to all persons.
 Christ Presbyterian Church
 Camp Hill

APPENDIX I: Remarks of Joseph W. Stella, D.O., President-Elect, Pennsylvania Osteopathic Association

Mr. Speaker, Guests, and Members of the House of Delegates of The Pennsylvania Medical Society:
 I am pleased to have been invited to attend this meeting and Mrs. Stella and I want to thank you for the many courtesies extended to us.
 I bring you greetings from The Pennsylvania Osteopathic Association and our best wishes for a most successful meeting.
 There are many problems that face our two professions and if we can't solve them by ourselves there are many who would love to solve them for us — the malpractice situation, the problems of pollution, drug abuse, over-population, physician shortage, physician image, the rising costs of medical care, and the overall threat of complete Federal control of medicine. Only we have the ability, knowledge and the right to solve these problems but we must solve them together. We know we can live together - we know we can work together - and we know that we must continue to

stand together in order to give our patients the best possible health care.

It has been good to break bread with you and it has been good to speak to you - it will be very good if we continue to meet and discuss what we mutually must discuss.
 Thank you.

APPENDIX J: Ninth Councilor District Supplemental Report (Referred to Reference Committee on Reports of Officers)

On September 10, 1970 a meeting of the presidents, secretaries and delegates of the Ninth Councilor District was held at Kittanning in Armstrong County. The meeting was interesting, informative, and I hope beneficial, with five of the six counties represented.
 Discussion covered subjects such as:
 1. Medical Care Foundation.
 2. Medical Society position on Abortion.
 3. Continuing education.
 4. Councilor District reorganization.
 5. Review of pending resolutions.
 6. In addition the subjects of utilization and Medicaid were discussed.
 The State Society staff representatives, David Small and Larry Fosselman, provided most of the answers. William A. Barrett, M.D., Pennsylvania Medical Society President, attended and gave an interesting and informative talk. The meeting was adjourned following a dinner.
 Respectfully submitted,
 Cyrus B. Slease, M.D., Trustee



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EDITOR'S NOTE

The purpose of this printing is to make available a book that serves a worthwhile purpose. Part of that purpose is to point up the changes that have occurred during the past two decades, allowing comparison with the old.

It is fitting that such a book should be authored by Roland I. Pritikin, M.D. A member of more societies than we could list on this page, this man has helped in staffing missionary hospitals and teaching students of ophthalmic surgery around the world. Yet the most significant achievements were those of everyday practice in which he has spent these last two decades, sharing in and contributing to the changes that have made a great specialty much greater.

Dr. Pritikin has honored me by asking for my editorial comments.

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REMEMBER—Nominate your county Benjamin Rush winners for the 1971 state competition. Entry deadline is February 1, 1971. Send your nominations to the PMS Council on Public Service.

⊙ Indicates membership in the Pennsylvania Medical Society at time of death.

⊙ **Elijah M. Ellsworth**, Kingston; University of Pennsylvania School of Medicine, 1917; age 76; died September 14, 1970. He was a former president of the Nesbitt Memorial Hospital and a recipient of the PMS Fifty-Year Award, and a Fifty-Year Award from the University of Pennsylvania Association. Surviving are his wife and a son, Robert M. Ellsworth, M.D.

⊙ **Henry R. O'Brien**, Camp Hill; University of Michigan School of Medicine, 1919; age 79; died August 16, 1970. In medicine for over fifty years he had served in the U. S. Public Health Service, the Rockefeller Foundation in Thailand and as the director of the division of professional education in the Pennsylvania Department of Health until his retirement in 1964. Survivors include his wife, a son and two daughters.

⊙ **Charlotte Nieb**, Erie; Stritch School of Medicine of Loyola University, 1934; age 64; died July 29, 1970. For the past nine years she had served as chief of physical medicine and rehabilitation at the Veterans Hospital in Erie. A sister and brother survive.

⊙ **George S. Pettis**, Reading; Hahnemann Medical College and Hospital, 1938; age 61, died July 22, 1970. He was one of the originators of the Community General Hospital's emergency department which he also staffed. He was chief of obstetrics at the hospital and a former Berks County Medical Society president. Survivors include his wife and two daughters.

⊙ **Irving Nissenbaum**, Reading; University of Tennessee College of Medicine, 1948; age 47; died August 10, 1970. He was the psychiatric medical director of the Family Children's Service in Lebanon County. He is survived by his wife, a son, Mark Nissenbaum, M.D., and two daughters.

⊙ **H. Malcolm Read**, York; Hahnemann Medical College and Hospital, 1915; age 77; died August 14, 1970. He was president of the York County Medical Society, a medical coordinator for the county's civil defense organization in 1951 and in 1958 he was named York County's "General Practitioner of the Year." He is survived by his wife and son.

⊙ **Carl B. Lechner**, Erie; Western Reserve University School of Medicine, 1935; age 62; died October 13, 1970. Dr. Lechner was a former president of the Pennsylvania Radiological Society and of the Erie County Medical Society. He also served as honorary past president of the Pennsylvania Medical Society and as medical editor of PENNSYLVANIA MEDICINE. He was the editor of the Erie County Medical Society publication, *The Stethoscope*, for five years. Surviving are his wife, three sons, a daughter, his mother, a brother and a sister.

⊙ **Paul O. Snoke**, Lancaster; University of Pennsylvania School of Medicine, 1924; age 72; died August 16, 1970. A radiologist, he was active in the establishment of the Lancaster County Health and Welfare Center and was a past president of the American Cancer Society. He is survived by his wife, a son, Edwin C. Snoke, M.D., and two daughters.

⊙ **Ray F. Tompkins**, Philipsburg; University of Pittsburgh School of Medicine, 1931; age 67; died August 6, 1970. Surviving are his wife and three children.

⊙ **Peter I. Zeedick**, Wexford; University of Pittsburgh School of Medicine, 1916; age 79; died August 14, 1970. He is survived by his wife, two daughters and a son, John F. Zeedick, M.D.

⊙ **August H. Becker**, Mt. Pleasant; University of Pittsburgh School of Medicine, 1944; age 51; died July 22, 1970. He served on the surgical staff of Henry Clay Frick Community Hospital. Dr. Becker was one of the founder members of the American Board of Abdominal Surgery. His wife, a son and a daughter survive.

⊙ **John F. Beauregard**, Pittsburgh; Yale University School of Medicine, 1939; age 58; died July 30, 1970. He was a practicing physician for twenty-four years and the owner of the John F. Beauregard Laboratories in Oakland. He served in the Army Medical Corps during World War II. Surviving are his wife, two daughters and a son.

⊙ **Paschal A. Linguiti**, Philadelphia; Temple University School of Medicine, 1941; age 55; died August 17, 1970. He is survived by his wife, four sons and a daughter.

⊙ **Chester G. Christ**, Gettysburg; Medico-Chirurgical College of Philadelphia, 1910; age 83; died July 17, 1970. He was a specialist in pulmonary disease, a past medical director of Gettysburg College and for thirty-four years was Adams County coroner. He is survived by his wife and a son.

⊙ **Henry D. Freiman**, Philadelphia; University of Pennsylvania School of Medicine, 1937; age 56; died August 17, 1970. Survivors include his wife, a daughter and two sons.

⊙ **Robert W. Guie**, Dunbar; University of Pittsburgh School of Medicine, 1945; age 50; died July 29, 1970. During World War II he served in the Army Medical Corps. He is survived by his wife and five children.

⊙ **James H. Howard**, York; Jefferson Medical College, 1910; age 84; died August 4, 1970. He was a former chief of York Hospital's obstetrical staff, where he practiced for over sixty years. He helped to organize the Planned Parenthood Program of York in 1935 and served as its director until 1967. Three daughters survive.

⊙ **Martin D. Kissen**, Philadelphia; Hahnemann Medical College, 1940; age 55; died July 27, 1970. Since 1966 Dr. Kissen had served as director of the Institute for Alcoholism and Narcotic Addiction, operated by the Pennsylvania Department of Health. Surviving are his wife, five daughters and two sons.

⊙ **Arthur R. McNeil**, Brookville; Medico-Chirurgical College of Philadelphia, 1905; age 91; died August 12, 1970. He was a past president of the Jefferson County Medical Society and of the Brookville Hospital staff. Surviving are his wife and son.

⊙ **Ralph L. Riviere**, New Brighton; Meharry Medical College, 1946; age 51; died August 18, 1970. He had been Beaver County coroner. His wife and a son survive.



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Constantine J. G. Cretekos, M.D., 300 Mt. Lebanon Blvd., Pittsburgh 15234.
William A. Feczko, M.D., 1205 Burch Field Rd., Allison Park 15101.
Lawrence Ferlan, M.D., 415 Fourth Ave., Tarentum 15084.
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Nadir Icli, M.D., 120 Ruskin Ave., Pittsburgh 15213.
John K. Irion, M.D., McKeesport Hospital, McKeesport 15132.
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Mark M. Ravitch, M.D., 3459 Fifth Ave., Montefiore Hospital, Pittsburgh 15213.
Richard B. Russman, M.D., 220 Meyran Ave., Pittsburgh 15213.
Harvey Slater, M.D., 4800 Friendship Ave., Pittsburgh 15224.
Ethel M. TaVoularis, M.D., Western Psychiatric Institute, Pittsburgh 15213.
Marshall W. Webster, Jr., M.D., 361 Ashland Ave., Pittsburgh 15228.
Edward S. Weisberg, M.D., 3600 Forbes Ave., Pittsburgh 15213.
Robert W. Williams, M.D., 676 Fruit Hurst Dr., Pittsburgh 15228.

BERKS COUNTY

- John R. Bower, M.D., 216 S. 6th St., W. Reading 19602.
Celedonia C. Valencia, M.D., 1515 Hill Rd., Reading 19602.

YORK COUNTY:

- Thomas L. Bauer, M.D., 748 Clearmont Rd., York 17403.
Stanley D. Freedman, M.D., 1280 Ruxton Rd., York 17403.

meetings

DECEMBER

The annual fall meeting of the Philadelphia Allergy Society, December 9, 1970, College of Physicians Bldg., Philadelphia.

JANUARY

National Conference on Cancer of the Colon and Rectum, January 7-9, 1971, Hotel del Coronado, San Diego, Calif. For information contact: Ronald N. Grant, M.D., Vice-President for Professional Education, American Cancer Society, 219 E. 42nd St., New York, N.Y. 10017.

FEBRUARY

Twenty-Third Annual Congress and Teaching Seminar of the International Academy of Proctology, February 26-March 5, 1971, Mexico City, Mexico. For information contact: Alfred J. Cantor, M.D., Executive Secretary, Executive Offices, 147-41 Sanford Ave., Flushing, N.Y. 11355.

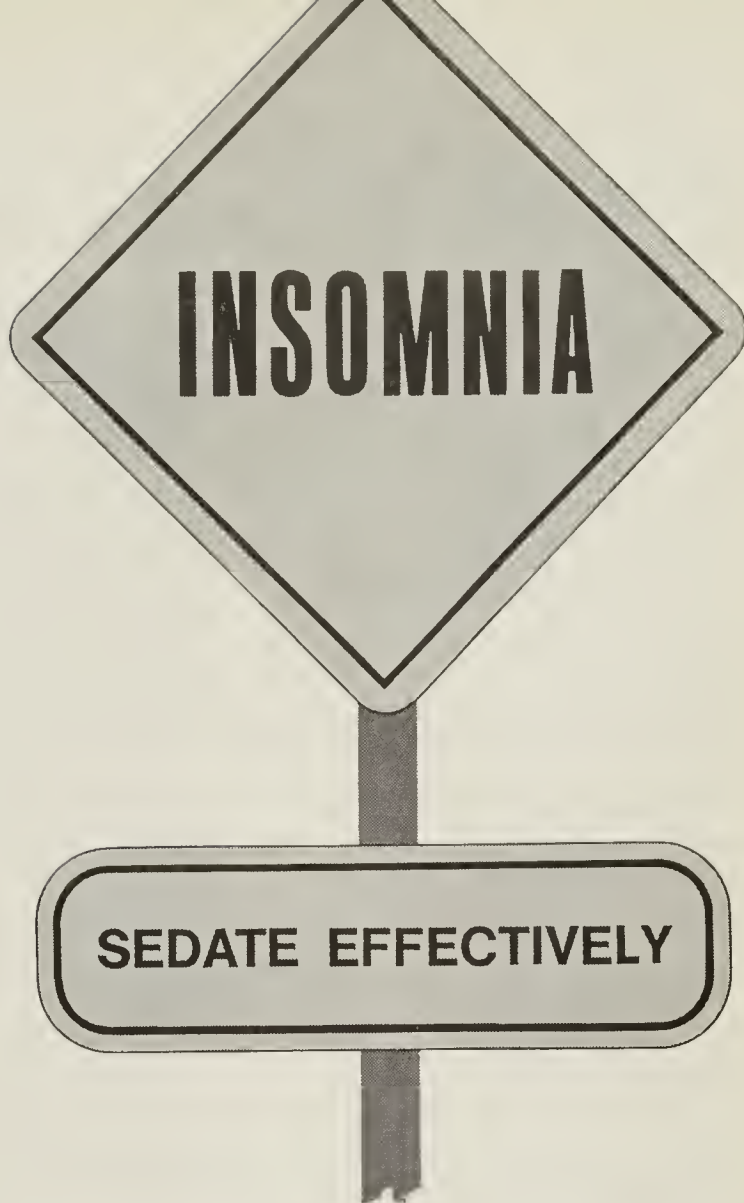
Twenty-Third Annual Clinical Conference of the Wills Eye Hospital, February 11-13, 1971, Philadelphia. Direct inquiries to: Robert D. Mulberger, M.D., Chairman, Annual Clinical Conference Committee, Wills Eye Hospital, 1601 Spring Garden St., Philadelphia, 19130.



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INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.
Altoona Hospital; fourth Thurs. ea. mo.
Greensburg (Westmoreland Hosp.); first Tues. ea. mo.
Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.
Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.
Uniontown Hospital; last Mon. ea. mo.
Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT

OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971

I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Educational Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 20, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

CODE KEY

C — Consecutive days
I — Intermittent
O — Circuit
PG — Postgraduate Traineeship
S — Designed for full-time specialists
AMA — AMA Accredited Institution
CES — Council on Education and Science, Pennsylvania Medical Society
Hahnemann — Hahnemann Medical College and Hospital
Hershey — Milton S. Hershey Medical Center
Jefferson — Jefferson Medical College of Philadelphia
Penn-Grad — University of Pennsylvania, Division of Graduate Medicine
Pitt — University of Pittsburgh School of Medicine
Pitt P.H. — University of Pittsburgh Graduate School of Public Health
Penn State — Pennsylvania State University
Temple — Temple University Health Sciences Center
U. of Pa. — University of Pennsylvania School of Medicine
Woman's — The Medical College of Philadelphia

Chester; September 8, 1970—May 25, 1971

I/AMA—POSTGRADUATE SEMINARS FOR PHYSICIANS; by Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

DuBois Hospital; February 4—April 8, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit

applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazleton State Gen. Hosp.; September 2, 1970—May 26, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazleton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazleton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster Gen. Hosp.; September 22, 1970—May 18, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17602.

Lancaster Osteopathic Hosp.; October 8, 1970—March 11, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602.

Lebanon; November 3, 1970—May 4, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John H. Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES;

every Wed., ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14—December 2, 1970

I—RECENT ADVANCES IN MEDICINE; at Temple; 1 day ea. week; 32 hrs. AAGP credit applied for; \$50 fee. Contact Albert J. Finestone, M.D., Clin. Prof. of Med, Temple, 3400 N. Broad St., Philadelphia 19140.

Pottsville; September 24, 1970—May 27, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert

Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; October 21, 1970—May 19, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Mercy Hosp.; 1 day a month; 8 months; 24 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grand View Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; \$25 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 hrs. AAGP credit applied for. \$35 fee (\$5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

York Hospital; September 17, 1970—April 29, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; \$40 fee (\$8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971.

I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; \$150 fee (\$70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS—CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.;

10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for; \$25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September—November, 1970 and February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 10 weeks ea. semester; 40 hrs. AAGP credit applied for; \$25 fee ea. semester. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September 24—December 3, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; every Thurs.; 10 weeks; 20 hrs. AAGP credit requested. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD; by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hrs. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia, 19139.

Philadelphia; September 30—December 2, 1970

I/AMA—SEXUAL PROBLEMS IN MEDICAL PRACTICE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 20 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 6—December 15, 1970

I/S—BEHAVIOR THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Hosp. of U. of Pa.; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970—April 6, 1971

I—MEDICAL HYPNOSIS; by The Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; \$150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 12—December 14, 1970

I/S—FAMILY THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at Phila. Child Guidance Clinic; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13—December 15, 1970

I/S—MARITAL THERAPY; by The Institute of the Pennsylvania Hosp. and U. of Pa.; at the Phila. Marriage Council; 2½ hrs. a day; 1 day a week; 10 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 14, 1970—March 3, 1971

I/AMA—PSYCHIATRIC PROBLEMS OF CHILDREN; at Hahnemann; every Wed. (except holidays); 18 weeks; 36 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. of Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 8—December 24, 1970

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF ALCOHOLISM, DRUG ADDICTION AND SEXUAL PROBLEMS; at The Institute of Pennsylvania Hospital; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; \$75 fee for 10-week session, \$150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 26—December 14, 1970

I/S—THERAPY OF PROBLEMS IN SEXUAL ADJUSTMENT; by The Institute of Pennsylvania Hospital and U. of Pa.; at The Institute; 1½ hrs. a day; 1 day a week; 8 weeks; \$50 fee. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 7—March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS;

at The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; \$50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—March 30, 1971

I/TREATING TODAY'S ADOLESCENT; by Institute of Pa. Hosp. of U. of Pa.; at The Institute; 1½ hrs. a day; 1 day per week 6 weeks. Fee \$50. Contact J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—April 27, 1971

I/TREATING SEXUAL INCOMPATIBILITY by Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. a day; 1 day per week; 10 weeks. Fee \$50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 22—March 29, 1971

I/PSYCHOPHARMACOLOGY; by Institute of Pa. Hosp. and Dept. of Psych. of U. of Pa.; at 111 N. 49th St.; 2 hrs. a day; 1 day a week; 6 weeks. Fee \$50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; April 7—May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; \$50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; \$75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27-29, 1971; Pittsburgh

C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; \$100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

May 6—7, 1971; Pittsburgh

C—PRE-INFARCTION PATIENT; by Pa. Heart Assoc.; at Chatham Center; 7 hrs. ea. day; 14 hrs. AAGP credit applied for; \$25 fee. Contact Royce J. Britton, Prg. Dir., Pa. Heart Assoc., P. O. Box 2435, Harrisburg 17105.

CHEST DISEASES

March 1-12, 1971; Philadelphia

PG-POSTGRADUATE COURSES IN BRONCHESOPHAGOGY; at Temple. Contact Charles M. Norris, M.D., Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

March 10, 1971; Sharon

C/AMA-MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE; by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

March 1971; Berks Co. Med. Soc., Reading
April 14, 1971; William Penn Hotel, Pittsburgh
May 1971; Conemaugh Valley Mem. Hosp., Johnstown
June 1971; Lehigh Valley Club, Allentown

O-MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit \$5 fee. Contact Comm. on Emerg. Med. Serv.,

Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

December 7-11, 1970; Philadelphia

C/AMA-EMERGENCY ROOM CARE (I Physicians); by Hahnemann; at Marriott Motor Hotel; 25 hrs. AAGP credit applied for; \$125 fee. Contact Wilbur W. Oaks, M.D., Prg. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 3, 1971; Harrisburg

C-DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

OBSTETRICS & GYNECOLOGY

December 3 and 4, 1970; Philadelphia

C/AMA-OFFICE GYNECOLOGY; two-day seminar; by Jefferson; at McClellan Hall; \$40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1971; Hershey Motor Lodge

C-12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; \$10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OTOLARYNGOLOGY

April 1-2, 1971; Philadelphia

Philadelphia; April 1-2, 1971.
C/AMA-THERAPY IN OTOLARYNGOLOGY; 1971 (Postgraduate symposium); by Jefferson; \$50 fee (\$10 to residents), includes luncheon both days and one dinner. Contact William Baltzell, M.D., Dept. of Otol., Jefferson, 1025 Walnut St., Philadelphia 19107.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park

C-SPORTS MEDICINE CONFERENCE; by CES and Penn State. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

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PHYSICIANS WANTED

Psychiatrist—Full or part time at accredited state mental hospital in suburban Pittsburgh; two geographic and one geriatric infirmary unit. Urban, educational, and professional benefits readily available. Requires two years experience and completion of three year residency. Pennsylvania license required. State fringe benefits. Salary—full time \$19,664 - \$22,768, part time \$16,978 - \$22,768. Superintendent, Dixmont State Hospital, Sewickley Pa. 15143. (412) 761-1780.

Physician—To provide medical services in a new neighborhood health center, to participate in the development and implementation of a physician's assistant (nurses, medical corpsmen) training program. Group practice setting, attractive hours, vacation, retirement, other fringe benefits. Salary \$27,000 - \$30,000 or higher, depending on qualifications. Write: Health Corporation of Luzerne County, 116-118 S. Main St., Wilkes-Barre, Pa. 18701. Near Pocono Mts., New York City 2¾ hrs., Philadelphia 2 hrs., Baltimore 3 hrs., Washington 4 hrs.

Psychiatric Physician—To be assistant superintendent and unit chief of accredited state mental hospital. Requires Pennsylvania license and four year's experience in psychiatry including three years in administrative or supervisory position. Salary \$21,672 - \$25,115. Superintendent, Dixmont State Hospital, Sewickley, Pa. 15143. (412) 761-1780.

Psychiatrists and physicians—Accredited hospital; approved psychiatric residency program, affiliated with approved general hospital. \$17,839 to \$25,115; housing possible. Pennsylvania license required. R. L. Gatski, M.D., Director, State Hospital, Danville, Pennsylvania 17821.

Physician—For general medical work at accredited state mental hospital—full or part time. Two separate county units and one geriatric infirmary unit. Assist with medical treatment and care of 560 patients. Pennsylvania license required. Salary—full time \$17,839 - \$20,629, part time \$15,387 - \$20,629. Superintendent, Dixmont State Hospital, Sewickley, Pa. 15143.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of five physiatrists. Three year program with opportunity for research and pursuit of special interests both in medical school and private hospital settings. One year's credit for four years of general practice experience or training in another speciality. Partially tax free stipends from \$8800.00 to \$10,000.00 depending on qualifications. GI schooling benefits available for veterans. Berry plan deferments are usually obtainable for physicians anticipating military service. We will pay for visits in selected cases. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Professor and Chairman
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Streets
Philadelphia, Pa. 19107
Telephone: (215) 829-6573

Wanted—Psychiatrists for Mental Hygiene Clinic operated within 951-bed modern neuropsychiatric hospital; immediate opening at salary range \$22,918-\$25,538; general practitioners interested in psychiatry welcomed; excellent working conditions in active cultural center and university affiliation; liberal fringe benefits; non-discrimination in employment. Write: Hospital Director, VA Hospital, Leech Farm Road, Pittsburgh, Pa. 15206, or call collect (412) 362-2000, ext 208 or 209.

Approved one year rotating internship—Available January 1, 1971, in 301 bed general hospital, Philadelphia suburb; ECFMG Permanent Certification required of foreign graduates; Exchange Visitor Number available; \$700 per month and full maintenance or extra living-out allowance; duty every third night and third week-end; active teaching and resident training program. Apply: Director of Medical Education, Delaware County Memorial Hospital, Drexel Hill, Penna. 19026.

Wanted: General practitioner to join active group in large non-ob, non-pediatric practice with a large industrial component. Well established. New building. X-ray - laboratory facilities - Cincinnati area. Future bonanza for right person willing to work. Write: Box 583, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

Wanted—M.D. or board certified in physical medicine. Coatesville Hospital, Coatesville, Pa. 19320. Phone (215) 384-9000, ext. 201.

Internist, certified or board eligible—To join established group in Pittsburgh practicing internal medicine with emphasis in rheumatology. Although responsibility predominantly in clinical practice, there is opportunity for post-graduate as well as under-graduate teaching at university affiliated hospital. Liberal stipend, commensurate with qualifications, first year, with progressive associate status, to equal membership in professional association. Write Box 581, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

Excellent opportunity for G.P., Emporium, Pa., county seat, Cameron County. Great hunting and fishing. Full employment, diversified industries. Modern hospital nearby. Office available. Chamber of Commerce, Emporium, Pa. 15834.

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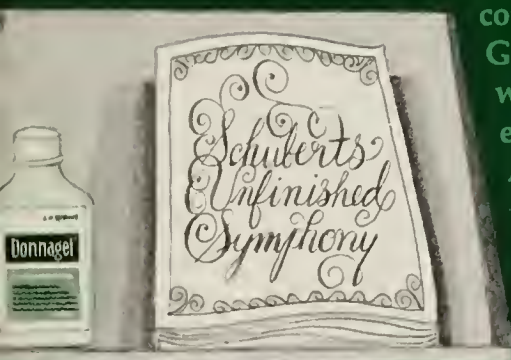
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**The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.**

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Each 5 cc. (1 teaspoonful) contains:
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Alcohol 3.5 per cent
KEEP THIS AND ALL MEDICINES
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FOR THE TEMPORARY RELIEF
OF COUGHS DUE TO COLDS

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COUGH SUPPRESSANT
Each 5 cc. (1 teaspoonful) contains:
Codeine phosphate 10.0 mg
Warning: May be habit forming
Glyceryl guaiacolate 100.0 mg
Phenacetin maleate 7.5 mg
Alcohol 3.5 per cent
In a palatable aromatic syrup
FOR THE TEMPORARY RELIEF
OF COUGHS DUE TO COLDS

4 FL. OZ. AH ROBINS
Robitussin-DM
EXPECTORANT
COUGH SUPPRESSANT
Each 5 cc. (1 teaspoonful) contains:
Glyceryl guaiacolate 100.0 mg
Dextromethorphan
hydrobromide 7.5 mg
Alcohol 1.4 per cent
In a palatable aromatic syrup
KEEP THIS AND ALL MEDICINES
OUT OF REACH OF CHILDREN
FOR THE TEMPORARY RELIEF
OF COUGHS DUE TO COLDS

4 FL. OZ. AH ROBINS
Robitussin-PE
EXPECTORANT
Each 5 cc. (1 teaspoonful) contains:
Glyceryl guaiacolate 100.0 mg
Phenacetin maleate 7.5 mg
Alcohol 1.4 per cent
In a palatable aromatic syrup
KEEP THIS AND ALL MEDICINES
OUT OF REACH OF CHILDREN
FOR THE TEMPORARY RELIEF
OF COUGHS DUE TO COLDS
4 FL. OZ.
For the temporary relief of colds and flu
due to the common
Cough Calmers
Robitussin-DM 6-8 hour
Cough Formula in
convenient dissolving form
11029068

[Faint, illegible handwriting covering the page]

